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ABSTRACT

In an exploratory study conducted for the Women's Action Program of HEW, the aims were to identify and explore the barriers to success that women face as MODVOPPP (Medicine, Osteopathic medicine, Dentistry, Veterinary medicine, Optometry, Podiatry, Pharmacy, and Public health) school applicants and students, and to describe the discrimination process, if any, that limits women's entry into the health professions. In this volume on podiatry, the profession's history, work focus, organization, and women's roles and status in it are reported. Current trends, issues, directions, and major changes in professional education are reviewed, and the professional training sequence (steps, requirements, criteria, and key factors) are outlined. The students' characteristics, along with what the profession is looking for in new members, are described. Special recommendations for the professional associations and for the schools are made, and statistical data, interview responses, and a bibliography are also included. (LBH)

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ED143294

AN EXPLORATORY STUDY OF WOMEN IN THE HEALTH PROFESSIONS SCHOOLS

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VOLUME VII: PODIATRY

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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WOMEN'S ACTION PROGRAM
Department of Health, Education, and Welfare

2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

THE EXPLORATORY STUDY OF WOMEN IN THE HEALTH PROFESSIONS SCHOOLS

We are enclosing the final report of The Exploratory Study of Women in the Health Professions Schools recently completed for the Women's Action Program. The information and recommendations it contains are intended for use by you and your respective institutions, agencies and organizations on policy, program, research, planning or affirmative action activities.

We hope that The Exploratory Study of Women in the Health Professions Schools will lead to greater awareness and understanding of the barriers women face as applicants to and students in the health professions schools. Further, we hope that the contents of this study will be useful in efforts to eliminate or minimize those barriers.

Connie Downey
Director, Women's Action Program
Office of Special Concerns
Office of the Assistant Secretary
for Planning and Evaluation
Fall 1976

EXPLORATORY STUDY OF WOMEN IN THE HEALTH PROFESSIONS SCHOOLS

VOLUME VII: WOMEN IN PODIATRY

Prepared for

The Women's Action Program
Office of Special Concerns,
Office of the Assistant Secretary for Planning and Evaluation,
Department of Health, Education, and Welfare

pursuant to

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Prepared by

URBAN AND RURAL SYSTEMS ASSOCIATES (URSA)
Pier 1-1/2, San Francisco, California 94111

1976

The opinions and conclusions expressed in this report are URSA's and do not necessarily reflect those of the Department of Health, Education,and Welfare.

In the classroom it's not cool to be a racist, but it's still cool, in some senses, to be a sexist. They can still get away with that. And in my mind, you know, like I just, I confronted one professor about singling out the women in the class, I said, 'Would you have done that with Blacks?' He wouldn't have had the nerve. He wouldn't dare. 'Would you have done that with Jews?' Heaven forbid. That would be, that would be disgusting. But to do it with women, it's cute. That's the only way I can make the point to these people sometimes because they feel that they have a handle on their racism. Even if you are a racist, you certainly don't express it in today's society if you're an educated person. You know better and it's frowned on socially. But sexism you can still get away with. (Third year student, female)

I feel that I have had a positive influence on a lot of my classmates. Like, the last day of school, after the final exams, we usually all go out and get smashed at the local bar and, it was funny, we got together and we were all drinking and I don't know how many guys came up to me, the type of thing when nobody else was looking and they had a few drinks under their belt, and said, 'I really want to thank you. You've really shown me that there are different types of women in the world. I really had a stereotype until I met someone like you.' That sort of thing does come out. I know it does come out to the other women in the class also and so it's a good feeling. It's something, I guess that maybe they don't talk about openly, maybe they do now. But some of the married guys have said this, that they are relating to their wives differently, better. You know, just having a few discussions with me and talking about women's rights and roles. (Third year student, female)

PREFACE

The Exploratory Study of Women in the Health Professions Schools was conducted by Urban and Rural Systems Associates (URSA) for the Women's Action Program (WAP) of the Department of Health, Education, and Welfare (HEW) under Contract Number HEW-OS-74-291. The study focuses on eight health professions generally known and referred to as the MODVOPPP professions: medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health.

Study Purpose

The study's central tasks have been to identify and explore the barriers to success which women face as MODVOPPP school applicants and students and to describe the discrimination process, if any, which limits women's entry into these health professions. Its central purpose--indeed its primary product--has been the development of conceptual models of the recruitment, admissions, and education systems designed to maximize equal opportunities for women and to encourage their success as school applicants and students in the MODVOPPP professions. The models are the basis for guidance and recommendations intended to assist HEW, the MODVOPPP educational and professional associations, the MODVOPPP schools, and appropriate others to eliminate barriers women face and/or to minimize their impact.

Study Design and Methods

The study was purposefully exploratory in its design. According to the Request for Proposal (RFP) which resulted in the contract, "The exploratory approach taken for this study is based upon the realization that not enough is known about the process of discrimination to permit more systematic research, or to assess alternative forms of intervention designed to achieve equal opportunity based on sex." A common purpose of exploratory studies is to identify and raise issues important to an understanding of a topic under investigation. The power of exploratory research is to illuminate issues in settings and systems which are complex and where simple variables and variable clusters are inadequate

to explain and establish causal relationships. Thus exploratory studies do not normally test hypotheses, they generate them. Their purpose is not to quantify the frequency, magnitude, or distribution of events or phenomena, nor do they measure statistical correlations among events or between events and characteristics of people, institutions, professions, or other categories of systems variables. Rather their purpose is often to define complex systems through descriptive or predictive models which may be subjected to a variety of tests or evaluations in subsequent stages of research. This study's goal of developing success models for women as applicants to and students in the MODVOPPP health professions schools was thus the basis for selecting an exploratory study design.

URSA implemented the design by collecting and analyzing extensive data about the MODVOPPP professions and schools and other pertinent topics and issues. Information was gathered from the following sources:

- Interviews with almost 600 individual MODVOPPP school administrators, faculty members, and students in 27 MODVOPPP schools around the country. These were open-ended, purposefully unstructured interviews designed to surface the widest possible range of issues from a broad spectrum of respondents. They were supplemented by over 60 group interviews in which an estimated 440 men and women students participated.
- Interviews and correspondence with staff members of the professional association, student association, women's professional association, and/or association of schools and colleges in each of the MODVOPPP professions.
- Written documents prepared by and collected from the MODVOPPP schools and associations such as recruitment brochures, school catalogues, financial aid (loan and scholarship) programs and policies, school admissions committee procedures, descriptions and instructions for use of centralized application services, and so on.
- The professions' various current and, when available, historic journals.

- Available statistics on the professions' practitioners, schools, applicants, and students.
- Interviews, correspondence, and meetings with individuals and groups conducting special studies and research in and about the professions, about women in the professions, sex role behavior and learning, and other related topics; and surveys of available studies, research, and relevant literature in these areas.
- Interviews, correspondence, and meetings with representatives of HEW health policy and program agencies and reviews of pertinent federal legislation, regulations, guidelines, and other documents related to health education policy and programs.

All of this information was subjected to qualitative forms of analysis intended to identify conflict and consensus among various sources of information regarding barriers women face as MODVOPPP applicants and students and to identify exemplary policies and programs sponsored by MODVOPPP schools and associations which appeared to eliminate and/or minimize the impact of these barriers. These analyses were the basis for developing the recruitment, admissions, and education models called for by the contract.

Scope of Study Research: Variations Among the MODVOPPP Professions

MODVOPPP students and schools are all designated as potential recipients of federal financial aid under the Comprehensive Health Manpower Training Act of 1971 (PL 92-157) Public Health Service Act; and schools receiving assistance under the Act are subject to its Title VII affirmative action and non-discrimination requirements.

Inclusion in this Act is the common basis on which the MODVOPPP professions were included in this study. Beyond this common feature, however, and the obvious fact that the MODVOPPP professions are all health professions, preliminary study research suggested that in many significant ways the professions are more different than they are similar and that these differences might have great significance for women as applicants to and students in the schools. The

MODVOPPP professions vary greatly in size, for example, with the largest, medicine, having well over 300,000 active practitioners and the smallest, podiatry, having barely more than 7,000. This variation also appears in the number of operational training institutions with medicine having over 100 schools and podiatry only five. The professions differ in public visibility and general knowledge. Everyone knows of doctors, dentists, and veterinarians and knows generally what they do. Not everyone knows what DOs (doctors of osteopathic medicine) or podiatrists are or what they do. Some of the professions are clearly defined as and accorded the social status and other rewards of a profession while others, in the public view, may be more often thought of as a good occupation or a good business. To some extent varying public definitions of profession vs. occupation vs. business reflect different practice patterns and organization. Some of the professions--for example, optometry--are more often practiced in entrepreneurial business forms such as solo or partnership practice than others such as public health which includes opportunities for practice in schools, hospitals, health departments, and other employer institutions.

Variations in professional training are also great. A first professional degree sufficient for practice is possible in some sections in public health within a year; in medicine the minimum is normally five years and the average, depending on specialty selection, much longer. Cost of training varies. Entry requirements to the schools vary. Curriculum content and structure among professions vary.

Finally, and most obviously, the presence of women as practitioners and as students, both historically and currently, varies enormously among the eight MODVOPPP professions, and some are much more heavily sex-typed than others. In pharmacy, for example, about 9% of the active practitioners were women in 1970; however, increasing enrollments of women in schools of pharmacy resulted in women representing 24% of first year enrollments in 1970-71. By contrast, women represented only 3% of active dentists in 1970 and only 2% of first year enrollments in 1970-71.

These most obvious differences among the professions--and others not so obvious--led the URSA study team to conclude that a portion of our research effort must be devoted to an examination of each of the MODVOPPP professions singly and as a separate and distinct social system with its own particular history, forms of practice, professional and training institutions, and practitioners and students. The purpose of conducting eight "mini-studies" on the MODVOPPP professions was to identify any characteristics of each profession--its history, organization, and other important features--which might contribute to an understanding of the role and status of women in that profession and to an identification of the barriers women face as applicants to and students in the profession's schools.

Organization and Contents of the Final Report(s)

As a result of our decision to conduct these studies of each MODVOPPP profession, the study's findings, conclusions, and recommendations are reported in a ten-volume final report. The ten volumes are:

VOLUME I:	Part 1:	DATA ANALYSIS, FINDINGS, CONCLUSIONS, RECOMMENDATIONS
	Part 2:	APPENDICES
VOLUME II:	MEDICINE	
VOLUME III:	OSTEOPATHIC MEDICINE	
VOLUME IV:	DENTISTRY	
VOLUME V:	VETERINARY MEDICINE	
VOLUME VI:	OPTOMETRY	
VOLUME VII:	PODIATRY	
VOLUME VIII:	PHARMACY	
VOLUME IX:	PUBLIC HEALTH	
VOLUME X:	ANNOTATED BIBLIOGRAPHY	

VOLUME I includes a discussion of the study's major findings regarding barriers women face as applicants to and students in the MODVOPPP professions. It presents the recruitment, admissions, and education models which are designed to eliminate those barriers. It suggests a series of further research and action

recommendations for attention by HEW, the MODVOPPP professional and educational associations, and the MODVOPPP schools. VOLUME I also presents a detailed description of the study's methods.

The several Appendices to VOLUME I include samples of the study's data collection and analysis instruments; a summary of the major issues raised by men and women students in group interviews; financial aid sources, policies, and problems students experience; a survey of the roles and status of women in the MODVOPPP professional associations; statistical tables used by the URSA study team in conjunction with field interview and document review data; and a discussion of data gaps confronting the researcher in the MODVOPPP health professions with recommendations regarding data needs. In this regard, it is important to note and to stress that both the relative absence of minorities in the MODVOPPP schools and professions coupled with the absence of statistical data about applicants, students, and practitioners available by both race and sex simultaneously has necessarily limited the findings and conclusions in this study to Caucasian women. To prevent such research limitations in the future, one of our most urgent data recommendations is that statistical data always be made available and presented by both minority status and sex together rather than singly.

VOLUMES II-IX, the individual MODVOPPP professions reports, are designed to serve as a brief introduction to each profession--an introduction which gives a sense of the profession's history, work focus, organization, and women's roles and status in it. The study's ANNOTATED BIBLIOGRAPHY, VOLUME X, includes a list of the major bibliographic sources used in our research and preparation of all of the study's reports.

Taken as a group, the eight individual professions' studies and reports include the bulk of the total study's findings and are the collective basis for the conclusions and recommendations presented in VOLUME I, DATA ANALYSIS, FINDINGS, CONCLUSIONS, RECOMMENDATIONS. Under optimal circumstances, each individual profession's report should be read in combination with and after VOLUME I. However, in anticipation of the possibility that individual profession's

volumes may be read alone, there is a certain amount of repetition and duplication of information among the eight professions reports and between them and VOLUME I.

In addition to serving as an introduction to each profession, VOLUMES II-IX also have two other purposes. First, each of the individual reports includes a short set of recommendations designed to address some of the problems women experience which are unique or particular to the profession and which are best considered for implementation by either the schools directly or by the profession's various key associations.

Second, the extensive use of direct quotes from our field interviews with administrator, faculty, and student respondents in school site visits provides a vivid description of women students' experiences in the male-oriented environments of the MODVOPPP health professional schools; the extent to which these experiences are unique to women and not shared by male students; and the extent to which these experiences serve as barriers to women as applicants to and students in the schools. Collectively these reports of women's experiences also demonstrate that in spite of the very real and significant size, structural, work, and practice differences among the eight MODVOPPP professions, women's experiences in these professions and their schools are more similar than they are different in many important ways.

WOMEN IN PODIATRY

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I. OVERVIEW

The profession of podiatry is the smallest and least well known of the health professions included in this study. Podiatrists are specialists in the care of the foot. Known officially as chiropody until 1958, the profession has grown from the status of itinerant "corn-pullers" in the 1830s to a sophisticated medical profession. Its function is now to

> ...diagnose, treat, operate and prescribe for any disease, injury deformity, or other condition of the foot, including surgery on the bones, muscles, or tendons of the feet for the correction of deficiencies and deformities of a mechanical and functional nature. (2)

Podiatry is small--there are about 8,000 licensed podiatrists in the US (1970 census), and six professional schools of podiatric medicine--but it is very much a profession. Its professional associations are well organized, politically effective, and actively engaged in attaining and maintaining high standards of training and practice. Podiatry students now experience a four-year curriculum which is similar in content and rigor to that of medicine. Post-graduate training programs increasingly prepare podiatrists for skills in surgery (ranging from replacement of joints with implants to plastic surgery), radiology, and dermatology.

Much of the energy that has gone into making podiatry a genuine medical profession has come out of the struggle for survival as a profession. Most of the itinerant healer professions, the "barbershop" professions, faded from sight when allopathic medicine won social agreement to its self-definition as the only legitimate healers. But as allopathic medicine grew, it showed little interest in certain parts and functions of the body, and these gaps in medicine's sphere of interest left gaps in the sphere of influence. Thus podiatric medicine has survived because podiatrists care for health problems generally neglected by allopathic medicine. Such a reason for existence is, however, a sometimes tenuous one: podiatric medicine has, in effect, been allowed to practice in interstices. And this leaves it vulnerable to a bordering allopathic medical specialty, orthopedic surgery.

An important part of the shape of the podiatric profession, both historically and at present, then, has been defined by struggles to gain professional legitimacy in the face of overt opposition from allopathic medicine. The label of "quacks" and

"patent medicine peddlers" remains an effective weapon against the original barbershop healers.

Podiatry has, despite this opposition, gradually attained many of the prerequisites for legitimate professional status. It has achieved practice statutes, professional training schools, legislative authority to perform surgery and prescribe drugs, and recognition by the military. Currently it is gradually attaining the extension of hospital privileges to podiatrists, board certification, university and health science center affiliation, postgraduate training programs and their accreditation, and inclusion of podiatry in key federal manpower legislation and federal health insurance eligibility rules.

Despite its many gains, podiatry today is still a profession with low visibility and still tenuous recognition. Though its small size contributes to its low visibility, it also allows a particular and effective style of professional activity. It is a tight-knit profession where nearly everybody knows nearly everybody else. Practitioners tend to cluster in the geographic areas near the schools--mostly East Coast and predominantly urban--thus creating a concentration of academic and practicing professionals. This enables the profession to organize effective recruitment efforts and to mobilize quickly around key political issues. A crisis in the viability of the profession in the late '50s and early '60s was met by vigorous response within the profession and followed closely by the inclusion of the profession in key federal legislation. This has made the profession both more dependent on federal support than the other MODVOPPP professions for its survival and heavily involved in national political affairs relating to health.

The practice of podiatry is characteristically primary and general care in nature. The trend toward advanced training will increase the skills of foot care practitioners, but is not necessarily geared to developing a new layer of elite podiatric medicine specialists. Rather, advanced training is aimed at providing a higher level of recognition to the profession and the individual practitioner.

Though access to hospital privileges and overcoming the hostility of orthopedic surgeons continue to create problems of legitimacy for the profession and of personal status for students and practitioners, podiatry is a profession with a good clientele. This means that though students may have some anxiety about their status vis-à-vis

allopathic medicine, we have found them to be a generally confident and optimistic group. Students see their prospects for a successful and lucrative practice to be good, and those with whom we talked seemed confident and confortable with their skills and abilities and about the prospects of a work life which they can design and control in terms of type of practice, income, and the hours they work.

Also, the important palliative care aspect of podiatric practice is crucial to students' and practitioners' view of their work. Because a podiatrist is very frequently confronted with conditions which have caused chronic and intense pain to patients and which the podiatrist can relieve often promptly and dramatically, podiatric practitioners and students are reinforced in their identity as healers. They can often relieve a patient's intense pain and thus receive a personal satisfaction and appreciation from the patient which is often denied other health professionals because of the nature of the problems with which they work.

We have found, then, the practitioners and academics in podiatry to be a tight knit, active group committed to their profession and deeply involved in the creation of its future as a legitimate and sophisticated medical profession. And we have found the students in schools of podiatry, though somewhat troubled by the status problems of the profession they are about to join, a generally confident group who look forward to a profession which they see as financially secure, adjustable to their life style preferences, and offering them the personal satisfaction of helping and healing in a tangible and rewarding way.

II. BRIEF HISTORY OF THE PROFESSION

INTRODUCTION

Perhaps due to the fact that podiatry is small and little known, it is a profession concerned with its history. No fewer than three recent issues of the Journal of the American Podiatric Association (JAPA) have been devoted to some element of podiatric history. The most ambitious of these efforts was the May 1974 Commemorative Issue. Because so few people know what a podiatrist is, almost every person who is associated with podiatry becomes an amateur podiatric historian just to explain to people what s/he does. One consequence of this "secondary scholarship" is that there are often many different versions of a story. The following attempt to provide an historical perspective on the profession of podiatry must be viewed, then, as our interpretation of the histories we have found.

THE EARLY YEARS: OUT OF THE BARBERSHOP

Corns, bunions, and foot deformities have plagued people since creation/evolution, and there have probably been healers to deal with them just as long. The first English treatise on "the cause of corns, warts, bunions, and other...cutaneous excrescences" was written in 1774 by a London physician, Dr. Low. He also coined the term chiropody. (17:279) A treatise on the cause and cure of corns was written by one Herman Lion in Edinburgh in 1802. (17:279) Mr. Lion revealed in that work that he was denied a medical degree because he practiced chiropody.

In the United States, the beginnings of chiropody/podiatry can be traced to the 1830s when numbers of itinerant "corn pullers" began to make the rounds of the major cities. The first chiropodist's office was opened in New York in 1843. In the 1840s, the Kennison Family practiced chiropody in the New England states. One of the family received an honorary doctorate upon becoming a state legislator, and other chiropodists began thirsting for similar recognition.

As time went by, offices were opened, and the profession began to stabilize. The most famous of the early practitioners was one Issachor Zacharie, the podiatrist and intimate of Abraham Lincoln. Zacharie is notable for his attempts to establish a podiatry corps in the Union Army to serve the infantry. His proposal was

rejected by the War Department and the Medical Corps and so began what has been a long fight to achieve parity with allopathic medicine in the military.

Although the profession made some strides forward in these early years, it was still considered in the late nineteenth century to be largely a cosmetic adjunct to the barbershop. There was no control of training and practice, and "corn doctors", like manicurists, often had to live on tips. (It is interesting to note that people in podiatry say, "We were the last out of the barbershop", choosing to refer to the barbershop as the source of almost all of the primary health professions.)

In 1895, the first critical step was taken in establishing chiropody as a credible and legitimate profession. A group of chiropodists petitioned the New York State Legislature for a law regulating practice. A bill was subsequently passed creating the Pedic Society, which was to serve as the board of examiners for the state until 1912, when a formal state board was set up. The Pedic Society remained the principal rule-making body for the profession in New York. In 1907, the Society published its first journal, The Pedic Society Items (later shortened to Pedic Items). The journal pushed for full national professional recognition and organization which was finally accomplished in 1912 with the creation of the National Association of Chiropodists (NAC).

The second critical step in the professionalization of chiropody was the establishment of a school. In 1912 The School of Chiropody of New York was established in response to the Pedic Society's petition of the New York Medical Board. Dr. Maurice J. Lewi, MD, the former Secretary of the New York Board of Medical Examiners, was installed as president, a position he held until his death in 1957.

THE MIDDLE YEARS: THE OFFICIAL EXPANSION

By 1920, over one-half of the states had established practice statutes, and six schools of chiropody had been formed (four of these have survived today). There were 3,784 licensed practitioners, approximately 38% of whom belonged to the NAC (17:283), and a Council of Education had been formed to accredit the schools and upgrade the curriculum and training standards of the profession.

However chiropodists were still denied full recognition by the military, having served merely as sergeants during World War I and then only in the Marine Corps.

Opposition, then as today, was led by the orthopedic surgeons in the military medical corps.

Any advance by the profession was then, and is today, met with significant vocal opposition by MDs. The podiatry profession has always been sensitive to and resented this opposition, but has always seemed ambivalent about confronting the medical profession directly.

The reason for this ambivalence is still the unresolved debate over whether podiatry's goal is to eventually incorporate with allopathic medicine as MD foot specialists or to remain a distinct professional enterprise. In the 1920s, Dr. Lewi believed that the strategy of the profession should be to incrementally upgrade the professional training process until graduates could honestly be awarded an MD degree. It was his feeling that podiatry should and would eventually be a medical sub-specialty. On the other hand, Mr. Graff, an early President of the National Association of Chirpody, contended that the profession of chiropody would die by becoming too expensive and elitist if too much training were required. Podiatry, he believed, had evolved out of medicine's neglect and therefore should remain apart from medicine to maintain its roots. The controversy persists today between academics and practitioners who seek to define the future of podiatry.

In the 1920s, chiropodists began establishing foot clinics, and in time some even gained appointments to prestigious centers like the Mayo Clinic. Also during the 1920s, several states began to recognize chiropodists as independent practitioners and gave them the authority to do surgery and prescribe drugs. This authority represents a major step forward in the professionalization of podiatry, for it provided podiatrists with the ability to have autonomy and authority over their own work and to include medically sophisticated procedures in their definition of professional work.

During the 30s, podiatrists attempted to further consolidate their position and to upgrade and professionalize. Shoe firms were attacked by the profession for trying to set up bogus foot experts, and attempts were made to restrict therapeutic shoes which were not either prescribed by or linked to a chiropodist. There was also movement to attain full recognition for chiropodists as independent healers in all states. As expected, this was fought by physicians, who, due to

the increasing crunch of the depression, were beginning to do more and more foot work to maintain their income.

In 1933, there were 539 chiropody school graduates (17:285), and the Council on Education, following the lead of medicine, concluded that the depression was no time to release a glut of podiatrists on the overburdened market. Accordingly, it moved for tighter entrance requirements (one year of college) and a longer training period (three years). This is an excellent case of the dynamics which have been and still are at work in the process of increasing professionalization in podiatry. When the profession has been threatened by forces challenging its professional status and legitimacy, and it has responded creatively by taking steps to increase training standards and the scientific base of its discipline. Rather than digging in their heels, the profession has defined the expedient response as the one which moves it toward increased professionalization. Recent moves to address federal requirements are in keeping with this pattern of response.

In 1938, the Illinois Medical Society forbade any affiliation between medical and schools of chiropody, but the Judicial Council of the American Medical Association (AMA) overruled this move and stated: "Chiropody is not a cult as is osteopathy [sic], chiropractic or Christian Science, which have non-scientific bases of treatment. Chiropody is an ancillary to the medical practice in a limited field considered not important enough for the physician and, therefore, too often neglected and fills a gap in the medical profession." (17:285)

With World War II, chiropody, once again, pressed for recognition by the military. Once again the profession was turned down. However in 1941, the Navy did establish a limited number of commissions for chiropodists (58 in 1944), (17:286). Unfortunately the other branches did not follow suit. Practicing chiropodists were deferred from the service, but chiropody students were not, causing some attrition. The six recognized schools had a combined freshman class of 108 in 1942, and the schools feared that this low enrollment situation would continue after the war. (17:286)

PHOENIX RISING FROM THE ASHES: CHIROPODY TO PODIATRY

After the war, there were approximately 7,000 active chiropodists in the United States. (17:286) New York allowed chiropodists to call themselves foot specialists and to give injections and prescribe drugs for foot ailments. Other

states soon followed suit. In order to consolidate the new status of the profession, a movement began to eliminate from the profession the old term of chiropody which conjured up the image of corn and wart remover. In 1958, practitioners were officially renamed podiatrist-chiropodists. The schools gradually became colleges of podiatry, then podiatric medicine. Gradually the old term was phased out altogether in the 1960s.

While the status of podiatry was improving, the schools of the profession were facing a real crisis. The enrollment drop, which first surfaced in the 1940s, reached some severe levels in the mid 1950s and early 1960s. (17:288)

ENROLLMENT IN ALL PODIATRY SCHOOLS

1952	1600
1963	510

GRADUATES FROM ALL PODIATRY SCHOOLS

1952	476
1960	112

Also during this time the number of schools diminished from eight to five. The most distressing loss was that of the Temple University School of Chiropody which graduated its last class in 1961. The school had long been one of the major innovative and professionalizing forces in the profession since its founding in 1915. Within a few years after Temple's closing, a new school was founded in Philadelphia, and its growth and development over the last decade is an example of the new vitality of the profession of podiatry.

The low point of the profession's recent history, then, was 1961. At that time the profession launched a concerted effort, still in progress today, to improve its image and the quality of its training institutions. That effort was initiated by the Selden Report and spearheaded by the Council of Podiatry Education (CPE), the profession's accrediting body of the American Podiatry Association (APA). The Selden Report, named for its major architect, Dr. William Selden of the National Commission on Accreditation, was the podiatry profession's "Flexner Report" and has become the blueprint for podiatry education. It called for strong basic sciences training, expansion of libraries, the addition of full-time faculty, especially clinical faculty, and the formulation of a

curriculum study. This curriculum study, headed by Lloyd Blauch, published a report in 1970 calling for further revisions and modification.

Alongside the effort to upgrade training in the schools has been a move toward continuing education through residency programs and general courses in emerging podiatric fields such as geriatrics, sports medicine, and podopediatrics (children's foot care). Beginning with the first residency programs established at Saint Luke's and Children's Medical Center in Philadelphia in the 1950s and followed by programs at Alameda Hospital in California, postgraduate education has grown today into a complex system of 179 CPE approved programs and numerous as yet unapproved programs. (2) This growth, coupled with the increasing demand of graduates for residency experience, compelled the APA and the American Association of Colleges of Podiatric Medicine (AACPM) to form the Central Application Service for Podiatric Residencies (CASPR) in the latter part of 1975. This service will attempt to coordinate residency placement throughout the country.

Perhaps the most important force which served to upgrade the position and status of the profession was the recognition afforded podiatry by the federal government in the 1960s in health manpower legislation. On the academic side the schools and students of podiatric medicine became eligible for federal support. This support has been most important, because the schools, private and freestanding in nature (except the proposed school at the State University of New York, Stony Brook [SUNY]), could not have improved and upgraded their physical plants and facilities without it. Moreover, through a series of legislative enactments during the 60s and 70s, podiatry services have been consistently recognized as eligible under Medicare, Medicaid, and other federal reimbursement programs. This in turn has encouraged non-federal sources such as third party insurance programs and Health Maintenance Organizations (HMOs) to include podiatric services in their programs. In short, the profession has come a long way, but much more ground must be crossed for the profession to be really secure. As one podiatry historian put it:

> The leitmotif of podiatry, from its start, seems to have been to convince the health world of its professionalism, as a field of practice, similar in many respects to that of the physician. Concern with and desire for the title of "doctor", the interest in having physicians as professors in its colleges, the deliberate modeling of the National Association of Chiropodists and the American Podiatry Association and their subsidiary groups and the Council on Podiatry

> Education and its accrediting policies on the American Medical Association and its formal structures and modes of operation, all illustrate this. With the apparent exception of the orthopedic surgeon, a large measure of recognition by the medical profession now appears to have been attained. (17:294)

THE HISTORY OF WOMEN IN PODIATRY

Of the MODVOPPP professions, only dentistry and optometry have proportionately fewer women practitioners than podiatry (see Table 1).

TABLE 1

NUMBER AND PERCENT OF ACTIVE PRACTITIONERS IN MODVOPPP HEALTH PROFESSIONS BY SEX: DECEMBER 31, 1970

	MEDICINE	OSTEOPATHIC MEDICINE	DENTISTRY	VETERINARY MEDICINE	OPTOMETRY	PODIATRY	PHARMACY	PUBLIC HEALTH
Total	311,210	12,000	102,220	25,920	18,440	7,100	129,290	N/A
Men	289,736	11,148	98,950	24,600	18,050	6,800	117,620	N/A
Women	21,474	852	3,270	1,320	390	300	11,670	N/A
% Men	93.1	92.9[a]	96.8	94.9	97.9	96.0	91.0	N/A
% Women	6.9	7.1[a]	3.2	5.1	2.1	4.0	9.0	N/A

SOURCE: *The Supply of Health Manpower, 1970 Profiles and Projections to 1990, Division of Manpower Intelligence, Bureau of Health Resources Development, Health Resources Administration, Public Health Service, Department of Health, Education and Welfare, 1974.*

[a] *Percentages estimated from subtracting DOs from MDs with MDs by sex in Women in Health Careers: Status of Women in Health Careers in the United States and Other Selected Countries, Chart Book for International Conference on Women in Health, The American Public Health Association, 1975.*

TABLE 2

FIRST YEAR FEMALE ENROLLMENTS IN MODVOPPP HEALTH PROFESSIONS SCHOOLS AS AVAILABLE FOR ACADEMIC YEARS 1968-69 THROUGH 1974-75

(BY PERCENT)

PERCENT WOMEN FIRST YEAR ENROLLMENT	MEDICINE	OSTEOPATHIC MEDICINE	DENTISTRY	VETERINARY MEDICINE	OPTOMETRY[a]	PODIATRY[b]	PHARMACY	PUBLIC HEALTH
1968-69	9.0%	4.0	0.9	9.0	-	-	20.1	N/A
1969-70	9.1%	2.4	1.3	10.9	2.5	-	22.7	N/A
1970-71	11.1%	2.7	2.1	10.1	3.7	2.5	23.7	N/A
1971-72	13.7%	4.3	3.1	15.3	5.3	2.0	25.8	N/A
1972-73	16.8%	6.9[c]	4.2	18.0	7.9	2.3	27.7	N/A
1973-74	19.7%	9.0	7.2	22.8[d]	11.3	4.0	29.0[e]	N/A
1974-75	22.2%[f]	10.9[f]	11.2[f]	24.4[d]	-	4.8	-	47.0[g]

SOURCE: *Minorities and Women in the Health Fields, Bureau of Health Resources Development, Health Resources Administration, Public Health Service and Department of Health, Education and Welfare, 1974 except:*

[a] *Unpublished statistical tables from the American Optometric Association, St. Louis, Missouri.*

[b] *Unpublished data from the American Association of Colleges of Podiatric Medicine, Washington, D.C.*

[c] *Journal of the American Osteopathic Association, Education Annual, 1974.*

[d] *Unpublished data from the American Veterinary Medical Association Association, Chicago, Illinois.*

[e] *American Journal of Pharmaceutical Education, "Report on Enrollment in Schools and Colleges of Pharmacy, First Semester, Term or Quarter, 1973-74", 1974.*

[f] *Women in Health Careers: Status of Women in Health Careers in the United States and Other Selected Countries, Chart Book for International Conference on Women in Health, The American Public Health Association, 1975.*

[g] *Association of Schools of Public Health; estimate since some unknown; excludes Puerto Rico*

This situation will continue for some time for a number of reasons. First, the percentage of women in podiatry is currently the lowest of any MODVOPPP profession. As of the 1975-76 school year, women represent less than 5% of the total enrollment in podiatry schools (see Table 2 on preceding page). (2)

The second factor which will keep women's overall representation in the profession at a low level for some time to come is an effect of the age distribution of active female podiatrists. There has been a dramatic decrease in the number of female podiatrists over the past twenty-five or so years, and this decrease will become even more marked as the more numerous older women podiatrists retire in the next decade.

TABLE 3

AGE DISTRIBUTION OF ACTIVE PODIATRISTS: 1970 (BY PERCENT)

	Under 35	35-44	45-54	55-64	65+
MEN	13.8%	21.1	28.7	26.8	9.6
WOMEN	3.1%	9.6	28.4	35.9	22.9
TOTAL	13.3%	20.6	28.7	27.2	10.2

SOURCE: Podiatry Manpower: A General Profile, Health Resources Administration/Public Health Service/Department of Health, Education and Welfare, 1970.

As the data in Table 3 show, the marked decline of women in podiatry is a relatively recent phenomenon. Today there are fewer women in podiatry than at any other time in the profession's history.

The podiatrists with whom we spoke to often suggested that the decline of women "began when we began to upgrade this profession"--that is, when the educational requirements and the curriculum were changed to include a heavier science emphasis. The data in Table 3 do not necessarily support this supposition since numerous women entered podiatry during the 1930s and 1940s, the time when the profession was establishing its scientific base.

The profession recognizes the current scarcity of women in its ranks and also the fact that this has not always been so. A recent recruitment brochure put out by the American Podiatry Association states the following:

> Podiatry historically has offered equal opportunity to women--they were among the founders of the American Podiatry Association. The colleges are anxious to increase today's unrealistically low enrollment of female students. (4:4)

Women have in fact always played a critical role in the profession. Originally, the term chiropody applied to both the hands and the feet and was seen as the cosmetic work of the manicurist. As the process of professionalization proceeded during the early twentieth century, women assumed significant roles. In 1912, at the initial meeting of the National Association of Chiropodists (NAC), 30 of the 100 delegates were women. (20:5) The nominating committee set up to choose the candidates for the first staff of officers for the association was made up of four women and three men. The record of the convention, the August 1912 The Pedic Society Items, shows numerous instances of female chiropodists addressing the convention whose "sentiments were loudly applauded, and made a great hit." While no women were selected officers for the first year of the association, two of the eight executive board members were women. (20:3) Lastly, of the 56 chiropodists listed as "reputable practitioners" by The Pedic Society Items on the back cover of its 1912 convention issue, at least ten (perhaps more due to the listing of initials instead of first names) were women. (20:39)

This active role of women did not end at the first NAC Convention. Women were active and instrumental in achieving recognition for their profession in the difficult fights that were waged state by state during the early years of professional podiatry. The August 1962 issue of the Journal of the American Podiatry Association, in commemorating the fiftieth anniversary of the national association, surveyed each of the fifty state podiatry associations to learn of their history and of the people who made that history. In no less than 28 states, women were identified as having played significant, often monumental, roles in setting up state societies, in getting licensing acts passed, and generally in being the founders of podiatry in the state. (26)

Recent years have seen the role of women in podiatry diminish along with their numbers, and the profession has been unable to attract women in any significant numbers. Recent efforts have been launched to expand the representation of women in schools and on faculties, but with the exception of a few committee chairships, women have not been represented in any important capacity within the profession in quite some time.

Perhaps the least known fact about the little known profession of podiatry is the important role that women have played in making it a viable and respected profession. Recent enrollment trends, combined with the age structure of women already in the profession, suggest that the total representation of women in the profession is bound to drop over the next few years. Some schools are trying to reverse the trend, but such efforts will have to be extensive and aggressive if they are to succeed.

III. THE PROFESSION TODAY

THE PROFESSION AND ITS SOCIAL IMAGE

Podiatrists are the first to acknowledge that their profession is handicapped by a public image which is at best blurred and ambiguous and at worst overtly critical. The public is, by and large, ignorant of podiatry and what it is all about. And the open hostility of orthopedic surgeons (the medical sub-specialists with responsibility for the foot) who have long barred podiatrists from practicing in allopathic hospitals, has kept alive a fuzzy reputation that podiatry is a holdover from the days of the patent medicine hawker duping the naive at the circus. No orthopedic surgeon would say exactly that, of course, but might rather dismiss podiatry as being "unscientific", its practice not "medicine" but "mechanics",and its practitioners not "doctors" but "technicians".

In fact, podiatrists share with practitioners of medicine, osteopathy, and dentistry the authority to make independent professional judgements and to administer medical and surgical treatment. But most podiatrists until recently have been forced to carry on their practices in their offices, isolated from other health professionals and ancillary health facilities.

Perhaps because of this isolation and "second class status" podiatrists have indeed "tried harder" to stress concern for their patient in both the academic and practice settings. Podiatrists appear to enjoy fierce loyalty from their patients. Much of this loyalty is based on the fact that a significant portion of traditional podiatric practice has been palliative in nature. Podiatrists are often the practitioner of last resort for patients who have long been living in agony and who seek the care of a podiatrist after years of unsuccessful allopathic medical treatment. Many of the traditional orthotic devices and techniques developed by podiatry and eschewed by medicine relieve pain without necessarily addressing the condition which created the pain. It is these devices which have given the profession its technical or mechanical image. Such devices are used today, however, only after competent examinations; and recent developments in the field have been focused upon the development of devices designed to treat the causes of foot diseases as well as their painful or uncomfortable symptoms. Unfortunately, podiatry is often known almost exclusively for the palliative care aspects of its practice rather than the

scientifically based surgical, pharmacological, and medical techniques which modern podiatric practice employs. (Though not a "cure", podiatry's palliative care techniques should not be dismissed since their effectiveness in eliminating pain has been quite important for many people's lives.)

Podiatrists are quick to stress the scientific base of their education which closely and quite favorably compares to the training of allopathic physicians, especially on the lower extremities. However with only five freestanding schools in operation, the profession lacks the resources to carry on significant research efforts. The primary goal of the schools has therefore been to turn out practitioners in numbers that will serve to expand the limited base of podiatrists in the nation.

THE PROFESSION AND PRACTICE OPTIONS, SETTINGS, OPERATIONS

Podiatrists have traditionally tended to have solo general practices. Recent trends have seen an increase in group or partnership practices, but solo practice still predominates for all graduates. Specialty areas have developed which allow practitioners to emphasize certain areas of practice, but it is still true that less than 10% of practicing podiatrists are exclusively specialists in practice. (10:10)

In 1970, 90% of active podiatrists classified themselves as holding a general practice. The remaining 10% classified themselves as follows. (10:23)

Exclusively surgical	5.7%
Exclusively foot orthopedics	2.5%
Podogeriatric, Dermatology, Roentgenology & Other	1.8%

While the above statistics suggest that specialization is not a significant practice mode, to the profession itself it reflects a marked change over previous years. In fact the movement toward specialization in certain areas such as surgery and biomechanics is considered by many to be one of the most important current trends affecting the profession.

The great majority of practicing podiatrists are engaged in direct patient care--99.5% of the male practitioners and 98.9% of the women. (11:27) More female podiatrists devote all of their time to patient care during the work week than do male podiatrists--80% and 65% respectively. (11:31) Other activities performed by podiatrists in addition to patient care are as follows. (11:27)

Activity	Men	Women
Teaching (College)	3.5%	1.0%
Research	7.0%	6.6%
Administrative	11.1%	8.0%

The great majority of podiatric practitioners are self-employed, primarily in solo practice, as Table 4 suggests.

TABLE 4

TYPE OF PRACTICE OF ACTIVE PODIATRISTS BY SEX: 1970

(BY PERCENT)

	Male	Female
Self-employed	93.8%	91.0%
Solo practice	85.9	76.8
Partnership	6.1	12.8
Group practice	1.8	1.4
Salaried in government	2.0	2.1
Salaried, non-government	2.2	3.1
Other	2.0	3.8

SOURCE: National Center for Health Statistics, Vital & Health Statistics, Series 14 #10, "Podiatry Manpower, A General Profile," USDHEW/DHS/HRA, March 1974, Table 9, page 25.

While the vast majority of active podiatrists are in solo practice, certain trends have begun to surface recently, especially in the under 35 age category. In fact the under 35 group exhibits practice characteristics which differ considerably from the over 35 group. Younger podiatrists are proportionately more likely to assume salaried positions. They are, however, not over-represented in teaching, research, or other non-patient care positions nor are they as yet overly represented on hospital staffs. Also, while they do gravitate

to self employment (78.4%), they are more likely to be involved in partnership or group practice settings (13%). (11:25) (See Table 4 for a comparison with all-age distribution.)

Podiatrists are rather unevenly distributed throughout the United States according to 1970 figures. (11:3)

Northeast	42%
North Central	29.1%
West	14.6%
South	13.9%

The highest ratios per 100,000 population were for the District of Columbia (8.1), Massachusetts (7.3), and New York (6.8), while the lowest ratios per 100,000 were in Mississippi (.4), South Carolina (.5) and Alabama and Hawaii (.6). (11:3) Such ratios of population to podiatrist are somewhat misleading. A study done for the APA on the location of podiatrists found that for the ten federal geographic regions, three had a positive or acceptable podiatrist to population ratio of under one to 10,000; three had neutral ratios between one to 10,000 and one to 13,000; and four had unacceptable distribution ratios of over one to 13,000. (3:10-11) The study further found that the location of the colleges of podiatric medicine had a strong influence on the distribution of podiatrists as did the lure of major urban SMSAs. (11:4)

For the aggressive practitioner podiatry can be a very lucrative and rewarding profession which does not carry with it the responsibilities and pressures surrounding the life and death of the individual patient. However the practitioner does suffer from general public ignorance and some active professional resistance to his/her desired calling. This has operated, as we have seen, to promote a geographic clustering of podiatrists around the schools and those metropolitan areas that recognize and desire their podiatrist's services. Also, the profession in recent years has taken on a decidedly male image despite the palliative and patient care emphases of podiatric practice.

Setting up a podiatry practice is not as costly for the young DPM (Doctor of Podiatric Medicine) as in certain other profession such as optometry and dentistry. Apart from the space required, the area of emphasis to be practiced

will dictate the type of surgical, x-ray, and orthotic/orthopedic equipment the new practitioner will need. The fact that podiatrists often do not have full hospital privileges does mean that much of the quipment, otherwise available in the hospital setting, will have to be duplicated in the office, thus necessitating a more significant start-up cost than an MD or DO (doctor of osteopathic medicine) could expect. While many of the students we interviewed in some of the other MODVOPPP professions (notably pharmacy, optometry, and public health/hospital administration) expressed concern and anxiety about their chances of finding jobs or being able to set up a viable practice, the podiatry students we talked with did not appear to have these concerns.

Since the profession of podiatry has not as yet consolidated its position and attained its full professional maturation and status, there are numerous vital issues and trends which are significant to its continued growth. During our limited inquiry, the following issues surfaced suggesting the need to examine them in some depth:

- changes in hospital privileges for podiatrists
- podiatry and current national health issues
- specialization within podiatry
- ancillary professions

Changes in Hospital Privileges for Podiatrists

One of the greatest practice problems for podiatrists is securing hospital privileges. About one-fourth of practicing podiatrists presently have some form of hospital privileges. Many major hospitals do not grant podiatrists in-patient privileges. In 1972, Stanford University Hospital became the only major teaching hospital to allow podiatrists surgical privileges.

The lack of hospital privileges serves to isolate the profession of podiatry and perpetuate a general lack of information about and an animosity to podiatry from other physicians. In the course of the study, several influential podiatrists revealed that they, themselves, achieved a certain parity and mutual respect with MD physicians only when they served together in MD hospitals. Without that exposure, the podiatrist is unable to break out of the stereotype

of him or her as a "corn cutter"--an opinion held by many MDs. Even the most progressive and often knowledgeable physicians apparently still believe that podiatrists are high school graduates whose professional training is basically technical, not scientific. Most MDs are ignorant of the fact that podiatrists are by and large college graduates when they enter schooling and leave only after four rigorous years of professional training is behind them. Podiatrists insist that the training a podiatrists receives on the human foot is far superior to anything an MD, even an orthopodic surgeon, receives. Unless and until the podiatrist is able to demonstrate his technical skills and medical expertise in the hospital setting, the profession will remain obscure and ignoble.

The issue of acceptance into hospitals has four interesting sidelights. First, podiatrists have been and will continue to be welcome to serve at osteopathic hospitals. A number of the APA approved residencies are at osteopathic hospitals. It is interesting to note that these two professions have maintained acceptable relations in the face of outward opposition. It is also interesting to note that both are aware of each others' professional competence and special skills while other MODVOPPP health professionals are ignorant of both.

Second, the California College of Podiatric Medicine has just opened a major health sciences center in San Francisco. The hospital will be the largest institution in the world devoted primarily to foot care. It will also open up research possibilities which will expand the prestige and practice of podiatry.

Third, all of the schools of podiatric medicine have established relationships with hospitals or clinics in their own communities to provide clinical rotations for their students. These relationships, once established, often provide the basis for both postgraduate podiatric residencies and the acceptability of podiatrists for hospital privileges.

Fourth, and most importantly in the long run, the California legislature has recently adopted legislation which is expected to greatly expand the position of podiatrists in the state. In effect, the legislation forbids hospitals from arbitrarily denying hospital privileges to podiatrists. Presently, a hospital is bound by its medical by-laws which identify what medical services are to be provided. These medical by-laws often do not mention podiatric services

specifically. Hence a podiatrist can be and often is denied privileges at a hospital regardless of his/her individual skills and competence because podiatric services are not specifically included in the by-laws. The new California legislation mandates that podiatric services be included in the medical by-laws of all licensed California hospitals. This will have the effect of opening new practice opportunity for the podiatrist in California. Through interviews with hospital administration students, URSA learned that the issue of including podiatric services in hospital by-laws has become a most sensitive one in California. Medical directors are expected to fight the required changes, and orthopedic surgeons will give much support to this fight. We learned that certain hospitals have completely ignored the issue in revising their medical by-laws and that others are expected to follow suit. It is, therefore, going to be an uphill battle for podiatrists in California.

The push for some form of advanced certification (see below) is one means that podiatrists may use in establishing hospital privileges. Influential podiatrists have revealed to us that there must be a strategy of selective placement adopted whereby certified or renowned podiatrists will make the first attempts to "blockbust" into major hospitals. Their success or lack of it will set the tone for future requests from less established podiatrists. It is expected to be an incremental process, but if the podiatrists of California are successful, other podiatrists and other state societies are expected to push for the opening of podiatric services in all hospitals.

Podiatry and Current National Health Issues

While much of the resurgence of podiatry has been the direct result of federal recognition of the profession, individual podiatrists differ in their opinion of national health insurance. Podiatry can be an extremely lucrative profession and at the same time does not require sixteen hour days of its practitioners. Thus, some podiatrists, like all medical professionals, would resist nationalization of the health care industry.

On the other hand, podiatrists have fought strenuously to be included in all third party payment plans, and they welcomed with relief the 1968 amendments to Medicare and Medicaid legislation which approved reimbursement for podiatric care. It is clear that the profession will resist any attempts to exclude it

from any federal program. The overriding issue involved is, therefore, parity with the other MODVOPPP professions.

As mentioned above, podiatrists are eligible for reimbursement from the federal government for Medicare patients. This was accomplished in 1968 by amending the Medicare Act to include podiatry in supplementary health insurance. Podiatry is also an acceptable service on some health plans including Blue Cross and Federal Employees Health Benefit plans. And the profession considered the institution of a permanent podiatry service at the Kaiser-Permanente Vallejo, California facility (1973), a prepaid group health plan, as one of the landmarks of the history of podiatry.

In 1974, recognizing the trend toward the establishment of group practices, especially for younger podiatrists, the APA developed a paper, entitled "The Role of Podiatry in Group Practice and Health Maintenance Organizations" which sought to explain the concept and to encourage podiatrists to seek out and participate in the newer approaches to the delivery of health care. The report notes that physician services as defined by the HMO Act of 1973 include the services of podiatrists. In contrast, the provision of dental, nursing, mental health, and pharmacy services is not well defined. With regard to group practice, the APA report acknowledges the existence of specialty specific groups, but emphasizes multi-specialty group practice which includes members of different health professions--MDs, DPMs, DDSs, etc.--and of different specialties--surgical, obstetrical, pediatric--practicing under a single legal entity.

The APA report, in essence, is the profession's attempt to demonstrate the importance of including a podiatrist in a multi-specialty group practice. It identified case studies promoting the inclusion of podiatric services in group or HMO operations, and developed a number of hypothetical situations which would show the desirability of podiatry services in different settings. Both this study and our interviews with a wide range of people in the profession demonstrate the almost unanimous enthusiasm podiatrists have for increased participation in HMO and group practice settings as well as the health team concept.

An additional issue of national health policy which has impact on podiatry is that of physician accountability. As we have noted, the history of podiatry is characterized by continuous sustained efforts of the profession to achieve status

and recognition. Recognition has come very late in the game, and then only through the force of federal legislation. Such legislation is not enough as yet to overcome the power of the medical profession and its widespread antipathy to podiatry. Accountability in the form of peer review is a power which podiatry surely wants to retain; the fear is that the profession may be monitored by its most vocal and consistent opponents, MDs.

After much wangling, a podiatrist was named to the Professional Standards Review Orgainzation (PSRO) task force of the AMA in 1973. The basic issue with podiatrists is, therefore, not that there be a professional peer review and accountability in the delivery of podiatric medical services but that such review be the responsibility of the profession of podiatry itself.

Specialization Within Podiatry

The current trend toward specialization has been discussed throughout this report. At the present time, however, very few podiatrists have exclusively specialty practices. With the increased demand for residency experiences has come the tendency to restrict practice to specific areas. As the profession grows, this trend can be expected to increase.

The impact of increased specialization upon the women in podiatry can be significant in the long run. None of the 31 prestigious residency positions controlled by the schools themselves was filled by a woman in 1974-75. (2:2) It is imperative that women not be excluded from specialty areas as they are developing, because this will tend to stereotype the area as a "man's preserve". Such stereotyping hurts both the profession and the women who are excluded. At the present time, there appears to be no defined "women's roles" or niches in the profession that women are expected to assume (outside of podopediatrics perhaps), and very few of our informants, male and female, disagreed with this assessment. The trend toward increased specialization may change this, and the profession should be aware.

Ancillary Professions

There is an emerging allied health professional called the podiatry assistant (PA). The Council on Podiatry Education (CPE) of the APA has tried to accredit the few podiatric assistant training programs now in existence, but, as yet,

neither the Committee on Post-Secondary Accreditation (COPA) nor the Office of Accreditation and Institutional Eligibility (OAIE/HEW) recognize the podiatric assistant as an allied health professional.

The term podiatric assistant is defined as an individual who, by virtue of education, training, and experience is qualified to provide support for the podiatrist in his or her service to patients. Regardless of the level of achievement of the podiatric assistant, s/he must perform all functions under the direction of a podiatrist. (7:2)

For a PA training program to be accredited by the CPE, the students must be under competent podiatric professional direction, and there must be a clinical phase directed by licensed podiatrists. Proper classroom and clinical facilities must be available. Candidates for admission into an accredited program must have a high school diploma or its equivalent. (7)

IV. PROFESSIONAL EDUCATION

CURRENT TRENDS AND ISSUES, DIRECTIONS, AND MAJOR CHANGES IN PROFESSIONAL EDUCATION

There are six schools of podiatric medicine in the United States, four of which were established prior to 1920. This is the smallest number of schools for any MODVOPPP profession. All of the schools, except one, are free standing private institutions. Recent statistics indicate that admissions are on the increase, and the position of podiatric education in the US is somewhat secure. The SUNY School of Podiatric Medicine, the first school affiliated with a medical sciences center, scheduled to open in Fall of 1975, was to be the model for all future new podiatry schools. Although an entering class of 27 students had already been accepted, difficulties with the enabling legislation for the school could not be resolved by the New York State at the time SUNY Podiatry was to open its doors. The fiscal crisis in the state was the real culprit, and the American Podiatry Association has begun negotiations with the State in the hopes that the school will be opened as soon as possible.

The five operating schools are located in San Francisco, Chicago, New York City, Cleveland, and Philadelphia. As mentioned above, practitioners have tended to cluster in the metropolitan areas. In fact, podiatry is perhaps the most urban-oriented of any of the MODVOPPP professions. Podiatrists often attribute the rather centralized nature of their profession to its rather low visibility within the health professions. The profession has grown largely through personal contact, and students have therefore tended to come from the areas where podiatrists are located.

Recently podiatry has experienced the same dramatic increase in applicants as the other MODVOPPP professions have. For example, the Pennsylvania College of Podiatric Medicine has had an increase in applicants from 185 in 1971-72 to 706 in 1975-76. The health manpower education legislation of the early 1970s spurred a general movement within the MODVOPPP professions, especially podiatry, to expand their enrollments. Overall podiatric medical school enrollments rose from 1,230 in 1970-71 to 2,086 in 1975-76, an increase of 70% over a five year period. (2:1)

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TABLE 5

PODIATRY SCHOOL ENROLLMENT: 1951-1976

Academic Year	Number of Schools	Enrollments		Students			
		Total	Women[a]	First Year	Women[a]	Graduates	Women[a]
1951-52	8	1,633				476	
1952-54	8						
1954-55	8			145[b]		161[b]	
1955-56	6	700		178[b]		142	
1956-57	6			159[b]		106[b]	
1957-58	6			139[b]		119[b]	
1958-59	6			122[b]		170[b]	
1959-60	5	465		131[b]		112	
1960-61	5	478		107		116	
1961-62	5	472		120		96	
1962-63	4	506		158		113	
1963-64	5	560		195		96	
1964-65	5	615		177		122	
1965-66	5	694		220		136	
1966-67	5	807		283		165	
1967-68	5	915		295		162	
1968-69	5	1,045		328		204	
1969-70	5	1,140	10[a]	300		260	3[a]
1970-71	5	1,230	16[a]	360	9[a]	270	5[a]
1971-72	5	1,320	16[a]	400	8[a]	310	1[a]
1972-73	5	1,401	21[a]	577	11[a]	259	1[a]
1973-74	5	1,531	40[a]	551	22[a]	305	4[a]
1974-75	6[b]	1,837	59[a]	561	27[a]	353	4[a]
1975-76	5[b]	2,086	100[a]				

SOURCES: Health Manpower Source Book, Public Health Service, 1968 Journal of the American Podiatry Association, May, 1974; Journal of Podiatry Education, June 1972; American Association of Colleges in Podiatry Medicine, January, 1976.

[a] *Consistent figures for women were not available prior to 1970.*

[b] *Students accepted to State University of New York-Stony Brook Podiatry were absorbed by the other schools.*

Table 5 records the changes in podiatric medical school enrollments over the past 25 years. Since the American Association of Colleges of Podiatric Medical Education (AACPM) did not become active until 1967, much of the enrollment data prior to this time is of uncertain accuracy. Female enrollments are included only for the period 1970 to the present.

The Federal Relationship to the Schools of Podiatry

Table 6 presents a summary of the funds received by schools of podiatry over a six-year period (1967-72, excluding capital improvement loans).

TABLE 6

FEDERAL ASSISTANCE TO COLLEGES OF PODIATRIC MEDICINE
(IN $1,000s)

Type of Assistance	1967	1968	1969	1970	1971	1972	Total
Financial Distress	--	--	--	--	--	135	135
Student Loans	204	235	306	167	334	433	1,679
Student Scholarships	51	109	160	227	208	203	958
Capitation	564	635	693	695	694	956	4,237
Special Project	--	918	1,053	1,007	866	1,560	5,404
Total by Year	819	1,897	2,212	2,096	2,102	3,287	12,413

SOURCE: American Podiatric Association, "The Relationship of Federal Funding to Podiatric Education," page 4.

In fiscal year 1972, three colleges of podiatric medicine received $1,560,000 in special project grant awards for increased enrollment, minority recruitment, planning for interdisciplinary training, and curriculum shortening.

Between 1967 and 1972, the increase in federal resources helped to bring about critical changes in the schools of podiatric education. These resources were used to increase student bodies, faculty, and educational support staff (see Table 7). Most important to the shape and future of podiatric medical education is the disproportionate increases engendered by federal funds in full-time faculty and educational support staff as compared with part-time faculty and enrollments. This means that faculty-student ratios have been improved. But perhaps even more important for the long run are the increases in full-time faculty as opposed to part-time faculty and support staff as opposed to faculty

and students. The podiatry schools have suffered as educational institutions from an extreme dependence on part-time faculty. More full-time faculty and support staff give the schools an essential core of people who can make a commitment to the school as an educational enterprise.

TABLE 7

INCREASE IN PODIATRY FACULTY: 1967-1972
(NUMBER AND PERCENT)

	1967	1972	% Increase
Full-Time Faculty	42	109	159.5%
Part-Time Faculty (by Full-Time Equivalent)	60	82	36.7
Total Full-Time Equivalent Faculty	102	191	87.3
Educational Support Staff	45	135	300.0
Enrollment	926	1,404	51.6

SOURCE: American Podiatry Association, "The Relationship of Federal Funding to Podiatric Education," page 8.

The federal role in podiatry school financing expanded during the 1967-72 period from 21% to 33% of all operating fund sources. Federal funding represented 41.42% of the operating income of the podiatry schools in 1972. This was a 10% increase over 1967 totals and suggests that the federal role has grown in importance over the years (see Table 8).

TABLE 8

OPERATING EXPENSES AND SOURCES OF INCOME 1967-68, 1972-73
($1,000s AND PERCENT)

	1967-68		1972-73	
	($1,000s)	Percent	($1,000s)	Percent
Total Operating Expense	2,637	100%	7,933	100%
Sources of Income				
Tuition	1,057	40.08%	3,377	42.56%
Student Loans & Scholarships	255	9.67	636	8.01
Other Federal	564	21.38	2,651[a]	33.41[b]
Miscellaneous-Other	761	28.85	1,269	16.00

[a] *Includes $1.2 million for capital improvement (building renovation) at one college.*

[b] *This becomes 18.29% when $1.2 million for capital improvement is deducted.*

SOURCE: American Podiatry Association, "The Relationship of Federal Funding to Podiatric Education," page 10.

In terms of student benefits through loans and grants, the picture is also quite significant. Table 9 marks the increase per capita per student over the period, 1967-72.

TABLE 9

PODIATRY STUDENT FEDERAL GRANTS: 1967-1972

(IN $1,000s)

Year	1967	1968	1969	1970	1971	1972	Total
1st yr Enrollment	291	331	293	351	400	473	
Total Enrollment	926	1,061	1,097	1,148	1,308	1,404	6,944
Total Grants	$819	$1,897	$2,212	$2,096	$2,102	$3,287	$12,413
Average/Student	.884	1.79	2.02	1.825	1.61	2.34	

SOURCE: American Podiatry Association, "The Relationship of Federal Funding to Podiatric Education," page 6.

In terms of actual support received, however, podiatry students do not appear to be doing all that well. In 1971-72, 38.6% of the total podiatry students enrolled received federal loans through the Health Professions Loan Program. In addition, 27.6% of all podiatry students received health professions scholarships.

In total, 43.8% of all podiatry students received some federal support. This compared favorably with medicine (37.2%), dentistry (43.7%), optometry (43.2%), and veterinary medicine (36.2%), while osteopathy (50.7%) and pharmacy (26.3%) varied from the norm somewhat.

However, in examining the average size of loans, it appears that podiatry students received less per capita than the other health professional students. While podiatry students must absorb the second highest cost for their education of the MODVOPPP professions (only osteopathy is higher on the average), 68.9% of podiatry student loan recipients in the 1971-72 school year received $1,000 or less, compared to only 51.6% of all MODVOPPP student loan recipients, (12:1) Moreover, 13.2% of medical school recipients and only 1.2% of podiatry school recipients received loans in excess of $2,000. (12:10)

When the basic support received by students is added to the capitation and capital improvement loan monies, podiatry schools received $21 million from the federal government over the period from 1968 to 1973. Federal funding formulas allocate more monies to medical schools than they do to freestanding podiatry schools. Though podiatry schools receive less money, they consider federal funding to be essential to their survival. This fact is borne out by the statements of AACPM spokesmen who emphasize their efforts to have Congress maintain and upgrade the federal share provided to podiatry. A more visible example is the fact that the AACPM fought and won a suit from the federal government overruling the Nixon Administration attempt to impound the capitation monies to the VOPPP schools. Podiatry was joined in its suit by the other professions, but it initiated and fought the suit almost single-handedly. (A full description of this crisis in podiatry education is available in "Impoundment of Health Funds by the Nixon Administration" in the Health Legislation Report Series of Science and Health Publications.)

Also, recent cutbacks in federal scholarship and loan support to podiatry students have placed hardships on them which seem to be more significant than those borne by other MODVOPPP students if our interviews are any indication. As one administrator put it:

> *The pressure on the poorer students is phenomenal. We can't provide enough support. The tuition can be swallowed into overhead, but that still leaves at least two-thirds needed to be provided. (VP for Student Affairs, male)*

Another more adamant view of the situation was voiced by this student:

> *I don't know whose responsibility it is, whether it is this institution, the federal government, state government, the city. The fact that a student was smart enough to get in here and may very well make a really fine physician, but has to leave because he doesn't have money, I think that's a disgrace when we have money for some of the other nonsensical, useless, stupid things but not useful and good things. And what could be better than to put a person through school? I can't imagine how you can rationalize, whoever does the rationalizing, I can't possibly imagine how he can rationalize this: it's not quite important enough to help a student go through school--it's more important to do a stupid study on women in the health professions. (Third year student, male)*

Perhaps the most telling quote came from this student:

> *All I know is that a lot of the younger men's wives don't even work because they have so much money. I also know a few women who couldn't come here because it was too expensive. I don't blame the school, I blame the government. The problem with podiatry is that you have to be rich to afford the training. It's sad now that they have to stress money. I bet you the quality of students is going down. It sure seems so. Those rich kids don't seem as smart, and they don't seem to care as much. (3rd year student, female)*

In summary, the recent moves to cut back federal support to health schools to student loans and grants will present special hardships for podiatry schools and podiatry students. Three of the six schools have received considerable support through federally insured and subsidized capital improvement loans, and all schools view federal capitation support as a critical resource in their budgeting. Moreover, the schools have relied upon special federal funding to improve their programs. The podiatry schools are sadly lacking in the faculty, equipment, and space that other professional schools take for granted and have used the resources and prestige afforded them by federal support to build their programs. If these resources were to dry up or be re-channeled, the schools and students would suffer much more than would the more established professions.

The Rise of the American Association of Colleges of Podiatric Medicine (AACPM)

The American Association of Colleges of Podiatric Medicine was established as the American Association of Colleges of Chiropody in 1932. It was not until 1967, however, that the AACPM was adequately staffed and began functioning as a true arm of the schools. Since that time a Journal has been established (1969), a professional aptitude test, the Colleges of Podiatry Admissions Test (CPAT), was developed; a central application service, the American Association of Colleges of Podiatric Medicine Application Services (AACPMAS) has been set up; and a central residency placement service, the Central Application Service for Podiatric Residencies (CASPR), has been initiated. Both of these latter services were set up to handle greatly expanded applicant pools (3,081 for 561 places in the 1974-75 entering class, and 500 applicants for less than 200 residency slots). (2) These services reflect the coordinated efforts of the schools, the AACPM, and the Council on Podiatry Education of the APA. The two services will provide the AACPM with important data to allow setting long range goals and objectives for the future of podiatry education. (See Appendix B for brief description of podiatry's professional organizations.)

Student Interest and Direction

One of the most important factors in podiatry education is the relationship of the students to the profession. A recent report of a poll taken of students at one of the podiatry schools showed that fully 50% of all first year students at college learned about podiatry from contact with a practicing podiatrist. Only 43% of the students polled said that podiatry was their first choice, and 17% were not sure how they felt about it. Other startling facts are that only 23% of the students polled knew about podiatry prior to college and that 26% of the students were less than fully satisfied with their choice. (24:7)

These attitudes about podiatry, and the relative dissatisfaction noted, may be important to the professionalization process. Both faculty and students suggest that special preference in admissions and residencies is still given to people with previous ties to the profession, but their numbers may not be that great. Hence, the profession, whose professional socialization process was traditionally sustained by family ties, may be having difficulties in dealing with the new podiatry student and socializing him or her into the profession.

Postgraduate Education and Continuing Education

Only four states require any type of postgraduate experience to qualify for the state license. But graduating students are seeking podiatric residencies in increasing numbers--estimates of 50% for 1974-75 and 80% for 1975-76--and the supply of available positions has not even approached the demand. (2) If the demand is to be met, the on-going efforts of the schools, the Residency Genesis Committee of the APA, the AACPM, and individual practitioners and graduates must be expanded over the next few years. These efforts must also be coordinated in part to adhere to the requirements of the Council on Podiatry Education which has responsibility for reviewing and approving podiatric residencies.

Recent events in podiatry have opened up the need to expand continuing education efforts for established practitioners. Practice issues such as sports medicine, or new developments in surgical or biomechanical techniques, and management issues such as the implication of proposed federal third party payment programs,

HMOs, and group practices are dealt with through the auspices of the schools. Problems ensue when there are no educational centers, as, for example, in the Northwest and the South. And efforts have been launched by state societies to provide on-going relevant information to their members.

THE PROFESSIONAL TRAINING SEQUENCE: MAIN STEPS, REQUIREMENTS, CRITERIA, AND KEY FACTORS

Overview

We have seen that one of the podiatry profession's most important means units struggle for legitimation, has been the upgrading of the training process. And we have seen that that process was begun in the 1920s with the initial accreditation of the schools of chiropody by the Council on Chiropody Education (now Podiatry Education, CPE), and that it was given new momentum in 1961 by the Selden Report.

The schools have cooperated in such actions as deciding on the terminal degree of Doctors of Podiatric Medicine (DPM) standardizing the requirements of preclinical and clinical curricula, standardizing entrance requirements, developing the CPAT examination, and centralizing the admissions process through AACPMAS. The individual schools have moved to full-time faculty appointments, upgrading faculty performance, and developing effective selection, training, and evaluation techniques. Today the entering student of podiatric medicine compares favorably with his/her peers in the other MODVOPPP professions in experience (over 80% of entering first year students have bachelor's degrees), knowledge (admissions science prerequisites are similar to other MODVOPPPs), and maturity (the average entering age of the students interviewed by URSA was 22). S/he can also expect to face four years of rigorous, sometimes grueling training which also compares with that received by those same peers.

The formal steps in the professional training sequence of podiatric medical education are as follows:

- Recruitment
- Application
- Admissions
  --Screening
  --Interviewing

--Selection

- Pre-clinical Training
- Clinical Training
- Postgraduate Training (Residencies, Preceptorships)
- Licensure
- Certification
- Practice
- Professional Political Action

Recruitment

Even though the Schools of Podiatric Medicine have experienced a dramatic increase in the number and quality of applicants, recruitment still represents a critical element of the admissions policies of the schools surveyed for the study. This is in contrast to professions such as medicine and veterinary medicine where the applicant/places ratio is very high. Largely because of the relative anonymity of the profession and of the institutions themselves, the need to aggressively recruit potential students is viewed as vital to the continued growth of the profession. The AACPM and APA recognize this fact and have prepared brochures designed to attract students to podiatry. While none of these is directed solely at women, all have statements aimed at women, and where pictures or artistic representations are used, women are made visible.

The actual process of recruitment at individual institutions varies somewhat, but it is clear that the private podiatrist plays an important role. This fact was borne out both by this study and by a recent article in the Journal of Podiatric Education which revealed that 50% of the first year class of one of the schools had learned of podiatry through contact with an active practitioner. (24:7) Both schools we visited send faculty and staff representatives to speak to pre-professional students at local (and sometimes distant) colleges and universities. These visits have recently emphasized active recruiting of women and minorities, neither of which are represented in any appreciable number in the profession.

Special recruitment tends to focus on minorities more than women, but creative recruitment programs for women are used by some schools. Women students and

practitioners are sometimes used by schools as on-site recruiters. Unfortunately these efforts have largely been directed at female undergraduate institutions because co-ed institutions have not favorably responded to recruitment efforts aimed at women. As one student recruiter said:

> *I do recruitment for the school, and it is terrible that I have only gone to women's colleges. I know that there are girls frustrated in co-ed colleges, in the pre-med type of scene, but they are not organized at all, and I can't get in to see them. When I write a letter to the [co-ed] school, asking if it can be given to the women in pre-med, it never gets to them. I only get responses from all-women's colleges. It is just that co-ed schools do not take care of their women in pre-med. I don't know if this is widespread, but it happens in this region. (4th year student, female)*

One of the schools we visited had been quite successful in encouraging women to decide on the school after a visit. As with other professional schools, students are often encouraged to visit the campus prior to admissions. Evidently, the way in which student guides conducted their tours was enough for a number of our female respondents to decide then and there to go to that school. As one third year woman put it:

> *I really did not know if I wanted podiatry, but I felt I would visit the school and see. Well, the tour I was given was wonderful. The guide really seemed to care about the school, and what was more important, he seemed to want me to come there. It just seemed so rosy.*

And another:

> *The podiatrist who visited my pre-med class said to come visit the school when you're in town, and then I got one of those student guides who has all this charisma and he takes you around and you fall in love with the whole place. (3rd year student, female)*

Recruitment is vital to podiatry's effort to expand its numbers of women and minorities. The most effective techniques appear to be the kind that allow a personable representative of the profession to explain its advantages to aspiring pre-medical students and to identify it as a viable career alternative. As one woman put it:

> *I don't think I would have come here if the podiatrist had not spoken to my pre-med class, because I wouldn't have been exposed to it. (3rd year student, female)*

As we have mentioned throughout this paper, podiatry is the least successful of the MODVOPPP professions in attracting women. Recent aggressive efforts have been somewhat successful, but systematic efforts will need to be sustained if the profession is to achieve its stated goal of attracting significant numbers of the women. One of the podiatry schools has set a goal of 40% women and 10% minority enrollment by 1980. The serious commitment represented by these goals (as opposed to quotas) is the kind that will be necessary if the profession wishes to replace the women it is going to lose through retirement and death over the next five years.

Application

The following excerpts from a recruitment brochure prepared by the APA, (4:3-4) sets out the background required of a prospective students.

> Minimum Entrance Requirements. A minimum of two years (60 semester hours or 90 quarter hours) of pre-podiatry education is required for entrance into a college of podiatric medicine. In the 1974-75 entering classes about 90 percent of the students had baccalaureate degrees or higher, and about 98 percent had completed three or more years of pre-podiatry education.
>
> Because of the large number of qualified applicants for the entering classes at the colleges of podiatric medicine, those applicants with the bachelor's degree generally are in a more favorably competitive position for admission.
>
> Included in the pre-podiatry education are required subjects and semester hours of credit (see Table 10).

TABLE 10

MINIMUM UNDERGRADUATE SEMESTER HOURS CREDIT IN SPECIFIC SUBJECTS REQUIRED FOR ADMISSION[a]

	Calif.	Ill.	N.Y.	Ohio	Penna.
English	6	6	6	6	6
Biology or Zoology[b]	8	8	8	8	8
Inorganic Chemistry[b]	8	8	8	8	8
Organic Chemistry[b]	4	3	8	4	4
Physics[b]	4	4	8	4	4
Humanities and Social Science	12	-	-	-	-

[a] *State University of New York-Stonybrook not included*

[b] *Including laboratory*

SOURCE: Podiatry Education: General Information for Prospective Students of Podiatric Medicine, American Podiatric Association 1975.

> Colleges of Podiatry Admission Test. All colleges of podiatric medicine require the Colleges of Podiatry Admission Test (CPAT) as part of the application procedure. The testing program is administered by the Educational Testing Services (ETS) under the sponsorship and direction of the American Association of Colleges of Podiatric Medicine.
>
> The three-hour test is designed to measure the academic aptitude and achievement important in the study of podiatry. It consists of separately timed sections covering verbal aptitude, quantitative aptitude, knowledge of subject matter in the natural sciences, and the ability to visualize spatial relationships. Separate scores are reported for each of the four sections.

The cost of the test is $25. Only a few of the students interviewed for the study said that they had also taken the Medical College Aptitude Test (MCAT) (presumably because they were also applying to medical school), and they revealed that, to them, the CPAT was easier.

In 1975, the AACPM in concert with the schools instituted its centralized application service for podiatry education. Through the services the basic application for each school has been standardized into one format. The cost of applying to the first school through AACPMAS is $30 with each subsequent school costing $15. The service has not yet been tested to see if it suffers from some of the problems that other professions have identified (for example, it eases and promotes multiple applications for those who can afford it; allows schools to drop students once they have been accepted elsewhere; greatly expands the number of applicants to a given school).

Admissions

The admissions process normally has three distinct phases to it: 1) screening, that is, a procedure to eliminate all but clearly qualified applicants; 2) interviewing; 3) selection.

Screening

Screening procedures vary from cut-and-dried formulae, such as assigning points for GPAs, CPAT scores, and recommendations to a more informal, or subjective, process of "sizing up" applications by an admissions officer. This may include

special attention to the application of women, minorities, veterans, and the disadvantaged and the underserved, and, as one of our respondents put it, a look at "some of the soft stuff--children of alumni, and prior exposure to the field." The more formula-based screening procedures often assign special bonus points if the applicant is a minority, a woman, a veteran, socio-economically disadvantaged, or from an underserved geographic area. These bonus points assist an applicant in getting through initial screening to the point of interview but do not weigh in their favor in the selection process.

Whatever the screening process, it is becoming a more difficult process because of the increase in applicants and the improved quality of applicants. Said one official:

> *The admissions process has been quite annoying these past few years. The average GPAs and test scores of students have been rising dramatically. It's clear that we are getting a better calibre of applicant, and it is getting increasingly more difficult to select a class because of it. (Admissions Officer, male)*

Interviewing

Interviewing is the responsibility of an admissions committee. The committees vary in style and composition. One school we visited does not allow students on the committee because, "they are not mature enough," while the other sees student interviewers and committee members as vital to the admissions process. One school uses interview panels of three to four members, often including a private practicing podiatrist, while the other usually conducts one-on-one interviews.

The content of the interviews obviously varies, but common points tend to be stressed. First, applicants are asked how they will finance their education. This was especially critical this past year because first year students did not receive much in the way of federal loans, and federal grants had been discontinued. The data is insufficient to support any real conclusions to the effect that the financial crunch is harder on women than men. But there were examples identified at both of the schools we visited where women who were accepted to the school had to turn it down because they could not arrange financing. It

was also true that of the nine women we contacted at one school, seven were supported by their parents.

A second common point is that a student's knowledge of and commitment to podiatry is heavily tested. The schools do not want students who come to podiatry only after having been rejected by another profession. Care is taken to identify the applicant's commitment to podiatry, but it remains an issue. As one woman student put it:

> *I am proud to be in podiatry, but some of the men are still insecure because medical school rejected them. I hope they get over it some day. (3rd year student, female)*

Schools sometimes train interviewers. We were told that this can be a helpful process for the interviewer and is perceived to improve the interview as an experience for the applicant and as a generator of comparable data for selection.

There was little, if any, mention of the interviews by the students interviewed for the study, male or female. Students did acknowledge that they were asked about their knowledge of podiatry and about how they were to finance their education, and at one of the schools women were asked "what about marriage and the family" questions. As one administrator put it, "I am not so much concerned about the answer, as the way the woman approaches it." Another administrator justified it as a perfectly valid question, even though the school had experienced relatively little female attrition due to marriage.

Selection

The schools appear relatively successful in retaining the students they eventually accept. In the schools we visited, 80% to 90% and even more of the applicants accepted by the school chose to enroll in school over the past five years. (The fact that there are only five schools may have something to do with this high acceptance/enrollment ratio. Only one of our student respondents had been accepted by more than one school of podiatric medicine.)

While the schools have been successful in general in attracting accepters, there is some evidence to suggest that women present a special problem. Table 11 illustrates the experience of one of the schools in retaining females.

TABLE 11

COMPARISON OF WOMEN ACCEPTEES AND WOMEN ENROLLEES
(NUMBER AND PERCENT)

Year	Women Accepted	Women Enrolled	Percent Accepted Who Enroll: Women	Percent Accepted Who Enroll: All Students
1975-76	20	16	80	90
1974-75	6	3	50	89
1973-74	7	1	14	88
1972-73	6	3	50	88
1971-72	5	3	60	84

Source: Confidential Field Data.

The school has attributed the low acceptance rate for women to a number of factors: the women choose to go elsewhere (i.e. medical school), or they change their minds about the commitment, but there are no ways to verify these claims. The only clear indication is that in some cases, some women have, by their own admission, been forced to reject podiatry school because they could not adequately finance their education. This appears to be a very significant problem for podiatry as earlier sections of this report have suggested.

Pre-Clinical Training

Podiatric pre-clinical training can be divided into three basic areas: the basic medical sciences taught in all medical schools; the podiatry-specific courses geared to providing students with the didactic elements of their specialty area; and professional courses geared at preparing the student for practice and attempting to socialize the student to the history, future, and general ethical concerns which mark the profession of podiatry.

Students entering podiatry school seem to know less of what the next four years will be like than other MODVOPPP students. This is partly due to the fact that podiatry and podiatric medical education is relatively unknown in the United States. Students may tend to consider entering podiatry late in their educational careers (average age 22.5 for men and 22.6 for women in our

study). Hence, their knowledge of the rigors of the education process may not be that great. For these reasons, orientation is a critical time when students are introduced to a new school, a new profession, and a new group of peers. In short, it can be a time for getting students off on the right foot. One school decided that orientation was the time to begin to alter a generally negative atmosphere that had become established. As one student put it:

> *For whatever reason, too many of us leave this institution not wanting to hear from it again. (Fourth year student, male)*

He and others worked with the administration to set up an atmosphere at the school which would change that attitude. The orientation of incoming students is where it begins, and if it has anything to do with the relative feelings the students in that institution have about their education, and it appears that it does, then the other podiatry schools should consider developing similar programs.

Data from our study and the figures on attrition in podiatry attest to the rigors of the pre-clinical years. Almost all of the students interviewed said that the first two years of podiatry school were grueling, especially when compared to the experiences of friends and acquaintances in allopathic medicine. A look at the attrition rate in podiatry schools (which occurs almost exclusively in the first two years) also presents some startling results. For example, of the 353 students (344 men and 9 women) who began training in 1970, 305 (301 men and 4 women) graduated. (2) The attrition rate for men was 12.5% and for women 55.6%, although the absolute number of women is too small to attach any significance without further analysis (see Table 12).

TABLE 12

ATTRITION RATES: GRADUATING CLASSES OF 1974, 1975

	ENTERING CLASS			GRADUATE CLASS			(PERCENT) ATTRITION RATE		
Class of	Men	Women	Total	Men	Women	Total	Men	Women	Total
1974	344	9	353	301	4	305	12.5	55.6	13.6
1975	392	8	400	349	4	353	11.0	50.0	11.8

SOURCE: American Association of Colleges in Podiatric Medicine, 1975.

Officials suggest that the current attrition rates experienced in podiatric medical education are lower than in past years. But the fact remains that they are high. Students attribute this to the interminable hours and constant work that is expected of them. Also, since patient contact is largely deferred until the third year, students often begin to lose sight of their original goals--to be practicing podiatrists--and to question the relevance of their education. This is a common complaint of all MODVOPPP students, but it appears to be especially prevalent among podiatry students.

One of the schools studied has tried to respond to the complaints of students by changes such as reducing the number of student/faculty contact hours per week, adopting a trimester system, sensitizing faculty and administration to the special needs of pre-clinical students. In the words of one administrator, these changes have gone a long way toward "taking the edge off the confrontation atmosphere that existed and making it more cooperative."

Clinical Training

Clinical training takes up the major part of the last two years. In contrast to the first two years, students consistently reveal that they have more free time during this period. There was also some widespread dissatisfaction voiced by students with their clinical experience. In general, this seems due to the limitations of the clinical settings available.

Schools generally have out-patient podiatry clinics which serve the local area and provide the basic clinical experience for the students. The most consistent problem noted by students and clinicians is that there are often too few patients to insure that each student will be able to perform a sufficient number of procedures. Moreover, the process of receiving patients through assignment, and the inability of students to follow a case through to conclusion are cited as deficiencies. Another consistent complaint heard was that clinicians often have neither the commitment nor the competence to adequately impart knowledge to their students. (Such complaints were recognized by administrators, who cite as significant problems of getting and retaining adequate clinical staffs. It is also notable that earlier clinical exposure has been experimented with somewhat successfully at both schools we visited.

In addition to their on-site clinics, schools maintain relationships with other health care institutions--hospitals, rest homes, and social service clinics--which often provide clinical placements for students. The experiences of students at these places varies. Often the exposure to other health professionals--especially physicians--provides students with a confidence in their own abilities. At other times the poor treatment received by students at the hands of their clinical superiors is often quite defeating. The key to these externship experiences is the monitoring of placement sites by the sending school. Both schools we visited are sensitive to the problems students encounter, and they try to maintain relationships only with those institutions which are receptive. However, considerations other than the individual student often control in the decision to retain or drop a referral site. These include the influence of the institutions and the desire to maintain relations, among others.

Apart from the general problems they encounter, most students we interviewed said that the clinical experience had improved considerably compared to when they entered. The constant change and flux in clinical training characterizes much of podiatric medical education. If anything can be said, it is that the schools are not standing still. One good example of this change is a school where the clinical staff has tried to improve upon its methods of evaluating student clinical performance. In the past few years three different forms were used, each an improvement and refinement over the other. Still, the department is not satisfied and is looking for new ways to change.

As mentioned earlier, none of the currently operating schools of podiatric medicine is tied to a university. Being freestanding institutions, the schools cannot draw upon the resources of a major campus. The result is that students must rely upon the federal and state governments for support. Since the schools serve more than one state, current plans are afoot for them to contract with outlying states (either through regional higher educational groupings or individually) to secure support for students trained from those states. This is a form of support which is common in professions such as veterinary medicine which has only 18 schools. The problem in podiatry is in securing the agreements.

Other services such as health care and child care are either not provided, or are provided for cost, because the economies of scale operating around such small institutions renders the free provision of such services too costly. Institutions do not normally have a physical plant that provides much in the way of recreational facilities, although athletic teams are often sponsored. Socially, schools like to promote a friendly "one-happy-family" atmosphere and are successful in varying degrees, success being measured by the amount of effort expended in promoting a happy atmosphere and on the energy devoted to assure it. Efforts in this are vary from trying very hard on several fronts--curriculum, counseling, social--to improve the atmosphere of the school to seeming indifference to the issue. This seems to make an enormous difference in students' attitudes toward the school.

Postgraduate Training (Residencies, Preceptorships)

Much has already been said about the increasing demand for postgraduate residencies and preceptorships, and the inability of the profession to keep up with this demand. In terms of our respondents, only one student, a woman, revealed that she would not actively seek a residency. The rest were quite concerned about obtaining one. This crisis has occasioned the creation of CASPR, the Central Application Service for Podiatric Residencies. Of the 500 applications reviewed by the AACPM through CASPR, fully 490 have been from fourth year students. (2) This total represents a much higher demand for residencies than was expected (50-60% of all students sought residencies in 1975).

Perhaps the greatest problem in a system that promotes such active competition is that objective criteria--i.e., podiatry school performance--often are not considered in selection. Students, faculty, and administrators agreed that there are glaring abuses in the way residents are selected and treated. Complaints of favoritism or special considerations are commonly made. There are no objective standards for selection, and reports are that it is sometimes based more on "who do you know" than "what do you know." This is not to say either that unfair selection processes are employed or that other MODVOPPP professions do not face the same problems. Rather, it is merely a recitation of opinions held by a large percentage of the people interviewed.

Apart from problems of objective selection, the residencies also present some problems for students. Reports are that podiatry residents receive less money than medical interns. Some programs are reported to provide such poor reimbursement that only people with outside sources of income can possibly take them. The question of whether such salary deficiencies create problems for married students or women is questionable, but the Council on Podiatry Education, which has responsibility for accrediting residency programs, should be sensitive to such issues.

A look at the "Criteria and Guidelines for Podiatric Residency Programs" (CPE, August 1974) reveals that CPE's basic concerns are that the programs serve the professional training needs of the resident. Such things as staffing, program content, program organization, facilities, and duration of residencies are considered. With regard to selection, the CPE mandates that a resident "should be a graduate of a college of podiatric medicine accredited by the CPE," and that the resident be worthy as to character, ethical conduct and clinical competence. (8:8) The guidelines do not state what criteria are to be used. With regard to salary, the guidelines suggest that the resident be given an employment contract which details duties, term, hours, stipend, fringes, and identifies a formal grievance procedure that the resident can use if disputes arise. There is no mention of the type and level of salary or fringes which should be provided, nor does there appear to be any movement to standardize residencies around these issues.

In discussion with officials of the AACPM and the CPE, we learned that they were aware of and concerned with the problems surrounding residencies and how they may have differential impacts upon women or married people. Unfortunately, the greatest problem is in generating a supply of positions to meet the demand, and until that happens, residents may be at the mercy of the programs training them. What is true is that more future research and analysis need to be done on the problem since it goes beyond the boundaries of this study.

Licensure

All states and the District of Columbia license podiatrists. All of the license acts are compulsory, requiring a license for any podiatric practice. The first state licensure law was passed in New Jersey in 1908. (13:129) Before 1920, over half of the states had enacted statutes. Apart from Alaska (1949) and Hawaii (1947), the last continental state to enact a podiatry statute was Arkansas in 1941. Twenty-three states have license boards comprised entirely of podiatrists.

Citizenship, either actual or through a declaration of intention to become naturalized, is a licensure requirement in all but seven states and the District of Columbia. In all jurisdictions, the minimum age for podiatry licensure is 21 years. The education and experience requirements for licensure vary somewhat. The pre-professional education requirement is two years of college in 32 states, one year of college in 16 states, and no specific requirements in two states. (13:133) All jurisdictions require a DPM (or PodD or DP) degree from an accredited college of podiatric medicine. In addition to the degree, the States of Michigan, New Jersey, and Rhode Island require one post-graduate year of internship or residency, while the state of Oklahoma requires either a 90-day preceptorship or one-year of internship/residency. This is a somewhat sensitive point because, as noted above, residency programs are a relatively new development in the profession, and there are far too few of them to meet the current demand by graduating students. Today only one-third to two-fifths of the DPM graduates can secure a one-year podiatric residency and less than 10% of those persons can obtain a two-year residency.

To obtain a license in any state requires the successful passage of a written state examination. As of 1968, 28 states often accepted certification of the National Board of Podiatry Examiners in lieu of their written exam. (13:133) In addition, 30 states require an interview and oral examination and 29 states require a practical/clinical examination of applicants for licensure. 13:133) Once received, a license is good for one year in 42 states, two years in seven states, and indefinitely in Mississippi. The cost of examinations runs from $15 to $100, renewals from $1 to $30, and reciprocity or endorsements from $20 to $200. (13:134)

Certification

At the present time, the DPM degree is licensed. Any subsequent training received by a podiatrist is irrelevant in all but four states. In 1970-72, in order to establish some legitimacy for its graduates, one of the colleges instituted a master's degree program for the two-year surgical residency program. Presently, the profession is in the process of establishing a national surgical board to certify podiatric surgeons. Prerequisites for such certification are expected to be membership in the American College of Foot Surgeons or the completion of an approved surgical residency. Other recognized podiatry sub-specialities such as orthopedics, dermatology, roentgenology, geriantology, or podopediatrics may, in the future, also push for some certification or recognition.

Podiatrists seek such certification as a further legitimization of their training and experience. The profession and its system of professional training have taken some significant strides in the past ten years, and there is some desire on the part of the profession to consolidate the gains already achieved and to walk forward into the future. The individual podiatrist desires certification to provide him or her with the credentials needed to obtain hospital privileges. Without certification or other credentialling, there is no way to distinguish one podiatrist from another, and as such, hospitals can and do justify their refusal of privileges to podiatrists who cannot provide the guarantees that an MD's specialty certification does.

Practice

There is no formal practice placement system operative within the profession or at the schools we visited. Students were concerned about residencies, but oddly not about practice.

Location of practice is an interesting issue. Podiatry is perhaps the most geographically centralized of the MODVOPPP professions. Owing to its small numbers, podiatry has not even truly saturated its cluster areas. As such, podiatrists are in demand and can establish lucrative practices with relative ease compared to some of the other MODVOPPP professions.

Professional Political Action

All podiatry students are sensitive to the opposition their profession faces from allopathic medicine. They also recognize the need to promote their profession whenever possible. This is perhaps why the schools are so successful in encouraging practicing podiatrists to actively recruit students for the profession. In another sense, podiatry is just beginning to take its place alongside the other MODVOPPP professions. There are many battles yet to be fought on the local, state, and national level before podiatrists will have achieved true parity. By and large, these battles will be fought by individual podiatrists working both within and without their professional associations. It is therefore believed critical by the profession that each student be educated not only in the skills of his/her profession but also in the means to assist the promotion and growth of the profession. There is an interesting agreement among podiatrists to promote their profession; an agreement which is not present so consistently in the other MODVOPPP professions.

V. PODIATRY STUDENTS

WHAT THE PROFESSION IS LOOKING FOR IN NEW MEMBERS (APPLICANTS/STUDENTS)

In our interviews we asked faculty, administrators, and professional association representatives what a podiatrist should be like and what qualities an aspiring podiatrist should have. Our respondents in podiatry emphasized qualities such as commitment to the profession, aggressiveness, and determination as did respondents in all of the MODVOPPP professions. But podiatry was in striking contrast to the other professions in its emphasis on the importance of sensitivity, compassion, and commitment to patients.

One broad view expressed by an administrator was:

> *Here, we went out and we tried to find some characteristics that the profession itself thought was important. What we found was that motivation to podiatry ranked very high. Also, people are concerned about sensitivity, which is defined to be the capacity for compassion and awareness of societal and professional needs. Empathy, or the ability to enter into the feelings of another person, is another important quality. Lastly, we look for aggressiveness or the ability to express a sense of direction and a determination to achieve one's goals. (Administrator, male)*

One female clinical instructor felt that dedication to patients was the key. In her words:

> *You have to be able to tell that they can put the patient first. I mean above everything. In school, they get so tied up in their classes that when they work in a clinic, sometimes they put their classes ahead. You can't put anything ahead of the patient. And I think that's the quality I look for.*
>
> *I think students are identical to being a doctor. You've got to have an interest in people. You've got to have this professionalism where you can work night and day. Patients are first. You're second. (Clinical faculty, female)*

Patient concern sentiments were voiced by students as well as faculty at the schools we visited. As a student put it:

> *Honestly, I think the integrity part is that no matter how your personal feelings are about anything, your primary concern is what is best for that patient. So as long as you have integrity*

and you are honest with the patient and always keep that patient's well-being number one, I think to me that this is the primary ingredient in medical integrity. (Fourth year student, male)

Also, speaking of integrity, another student said:

Podiatry like any medical profession has to have a different morality than any other type of business. You gotta treat your patients with respect, and I think that's integrity. You know, you can't try to make it like a plumber or something where you can just leave it leaky enough so you gotta come back, or planned obsolescence--that just doesn't exist. (Fourth year student, male)

In general, the sentiments expressed by faculty, administrators, and students suggest that some basic human qualities are revered over "mere intelligence".

There were two interesting points of view expressed about the characteristics needed for the future. The first view as expressed by a male administrator is as follows:

As the profession is upgraded and becomes more visible, there is a need for a more qualified student and practitioner. The only way recognition is to be attained is by practitioners exhibiting excellence in their work. Women are a group who can bring much to the profession if they strive to excel on the outside as they have done here. (Administrator, male)

A contrary view was expressed by a faculty member:

Podiatry is a very publicized profession. Everyone is very concerned about maintaining the proper posture and image. Even dress and appearance is considered very critical here. As such, the profession is too uptight to seek the aggressive entry of women and minorities, because it may look bad to the outside. (Faculty, male)

As the above quotes indicate, there is no clear definition of need. In a profession that is moving as fast as podiatry, there will be the inevitable growing pains and difference of opinion. It does appear rather interesting though that almost all within the profession agree that they cannot conduct their affairs within a vacuum. There appears to be a consensus around the need to promote the profession to the public, the government, and the other health professions.

WHO THE STUDENTS ARE

Demographic Characteristics

Podiatry students appear to be older than their peers in the other MODVOPPP professions. For example, the average entering age for the students interviewed for the study was 24 for the men and 23.4 for the women. The ranges were from 19 to 33 for the women and 20 to 30 for the men. The high age of entering students suggests the possibility that podiatry also has a high proportion of married students. The October, 1973 DHEW Report entitled How Health Professional Students Finance Their Education found that podiatry students shared with osteopathy and dentistry the highest proportion of married students in the MODVOPPPs. (9:1) The figures indicate that 52 % of podiatry students during 1973-74 were married, and the corresponding figure for 1974-75 was 51.4%. (2) Six of the 11 men and six of the 13 women also partipating in the present study were married.

The HEW study found that marital status was the single most important factor in determining both the expenses and income of students in MODVOPPP schools (9:1). It also found that podiatry ranked second among the MODVOPPP professions in annual educational expenses with the average being $6,302 per year, fully $800 more than for medical students. (9:10)

Also, according to the HEW study, podiatry students come from less affluent backgrounds than their peers in medicine, osteopathy, and dentistry. At the same time, they do tend to be the sons and daughters of professional men and women. Two of the students we interviewed had mothers who were podiatrists, and nine of the 13 women revealed that either or both of their parents were college graduates. The same was true of nine of the 11 men. The students of podiatry and osteopathy come from metropolitan areas more often than do students of the other MODVOPPPs. (9:9) Eighteen of our 24 students come from such areas, and 17 of them had lived within 500 miles of the school they were then attending.

While it is difficult to obtain data on average grades and test scores, it is clear that both have been consistently rising over the last few years. One of the schools we visited revealed that its most recent entering class had a mean GPA of 3.1 (women 3.3) and a mean CPAT score of 225 (women 215). These are all evidently higher grades than were recorded in previous years. The other school reported the same increase in the qualifications of entering students.

Observers consider the overwhelming increase in applicants to be the most significant factor in this increase. The situation has changed dramatically in just a few years. For example, in 1969-70, 69.3% of all persons taking the CPAT exam were admitted into podiatry school. In 1974-75, this figure had shrunk to 36%. (2)

Reasons for Being Attracted to the Profession

Those student who had a significant prior knowledge of podiatry often gravitated to it because of the special image that podiatry has of being a profession that can relieve pain. This palliative image influenced some students to decide on podiatry. For example:

> *I had gone from doctor to doctor for my feet. My mother-in-law suggested a podiatrist, and I balked because I had come from a medical family. Well, I went in and the doctor actually helped me. And when I said I was interested in medicine, right then and there he tried to get me to go into podiatry. I worked a little with him and saw how much good he did, and, well, here I am. (Resident, male)*

Or, another student:

> *It always appealed to me the way people could come in pain and leave relieved. It made a big impact on me, that ability we have to really ease pain. (Fourth year student, male)*

Or, put another way, by a third-year woman:

> *Oh, I liked working with my hands and doing something, but the thing that I really like about it is that, guaranteed, about 99.9% of patients that come into my office, not all of them will be in pain, but of those who have discomfort, whatever it may be, I'm not going to say that they're going to be cured, but every one of them is going to go out feeling better.*

Other students were attracted to podiatry because of the life style one could lead. For example:

> *It is a profession that does not force you to be responsible for life and death decisions daily. You can work sensible hours and still make a very lucrative living. That is why I chose it. (Second year student, male)*

And:

> *I specifically chose this for many reasons. For one, you don't have house calls in the middle of the night. It's very conceivable to have a family and to live harmoniously with the family in a*

family setting, with children, and still practice. And on top of that, you are independent and can make professional medical judgments on your own. (Third year student, female)

It is interesting to note that both men and women cite life style flexibility as a factor. It is often assumed that only women have such concerns, but we have found men frequently voicing this issue in all of the MODVOPPP professions.

Routes to the Profession

This has been discussed at length elsewhere in this report, but there are certain trends that need to be identified. Recruitment was an important device in attracting women to one school we visited while a majority of both men and women at the other school learned of podiatry through a friend or relative who was a practitioner.

As mentioned earlier, the age of entering students is quite high for the MODVOPPP professions. In addition, some of the students switched to podiatry from other careers. The 1974-75 Annual Report of the AACPM on podiatry students revealed that there were four Pharm Ds, 73 with master's degrees, and three PhDs among the 1,837 podiatry students. (2) Ten of the 24 students interviewed in the study (four female, six male) had left other careers to enter podiatry.

While officials suggest this is changing, another significant route to the profession appreantly is a second choice after rejections from another career (typically allopathic medicine). According to background interview forms, we used with students we interviewed individually, of the 11 male students contacted, six stated that podiatry was their first choice for a health profession. Of the remaining five, four said allopathic medicine had been their first choice, and one said pharmacy had been (he was already a pharmacist).

Of the 13 females who participated in the study, ten said that podiatry had been their first choice. In fact, none of the women even applied to schools in other professions. Of the three who said podiatry was a second choice, allopathic medicine was the first choice, and one woman is still contemplating medical school and may go after her second year.

This may suggest that podiatry is more often a first choice profession for women than for men. The women had some interesting statements to make on their choice of profession and their difference from men in this regard. As one second year student said:

> *I am proud to be a podiatrist. I don't have too much of an inferiority complex about it. You know, like, I think a lot of the guys do. A lot of the guys that are here applied to medical school and didn't get in and got in here. So, even in their own view of themselves, it was their second choice. But I don't know if that is going to continue. Each year, the grade point average of the students entering are rising, so it's becoming more competitive all the time. I'm happy; it was my first choice. I like podiatry. It's the type of thing where it's, it's just a great profession. (Second year student, female)*

Another student put it this way:

> *I thought I would like to go into podiatry. And I never really thought about going for general medicine, to med school. It wasn't because I had applied and didn't get accepted, which has been the case for many students here. (First year student, female)*

And still another added:

> *Many of the men tried to get into medical school, couldn't make it, so then they tried here and they got in and it's sad because you could tell they're not happy. Some of them...they've applied to other medical schools after their first year and after their second hoping that the medical schools will see that they are sincere in their desire, but it's not that they're not happy because they don't want to be restricted to just the foot or just the leg. I guess they just want to be MDs. (Second year student, female)*

Assessment of the Profession from the Inside

As noted throughout this report, most of the people connected with podiatry are concerned about the image of the profession. They realize that most people, including other health professionals, are ignorant of the recent strides made in upgrading the curriculum, student credentials, and practice techniques. As such, they are sensitive to charges that the profession is not scientifically based, that practitioners are technicians rather than physicians, or that the schools are inferior. This sensitivity shows up internally through a general message that students as well as practitioners affect a professional,

mature posture. Appearance as well as demeanor is considered here. At both study schools, the men wear ties and the women skirts or slacks. Denims or jeans were conspicuous by their absence. Moreover, in the male group interview conducted at one school, one attribute of a good podiatrist was said to be "a person who is well groomed, with a professional appearance."

Other examples of this sensitivity to the image of the profession are more subtle. For example, people assumed that our survey team did not know much about podiatry and were happy to explain all that they could. This is in contrast to allopathic medicine, where both students and faculty assumed that one would know all but the most technical terms. This contrast between the relative confidence of allopathic medical students and the relative insecurity and occasional defensiveness of the podiatric medical students provides a much more telling picture of the differences between the professions than would any comparison of the differences in curricula or medical training experiences that the two professions provide.

The relationships between and among podiatry students of both sexes are quite interesting. The women often had difficulty in relating to each other and to their male peers. Our data from other MODVOPPP professions where women are present in much higher numbers suggest that this problem decreases and disappears when a higher proportion of women are in the setting. The following are statements that illustrate the various problems with peer relationships.

One woman student talked about feeling like a mascot:

> *In my class there are 100 people, but there are only three women. We are rather tokens, mascots or something for the class, you know what I mean? Our numbers aren't great enough to be threatening to them, so with three women in the class, they can handle it, you know what I mean? But when it was mentioned that there would be a lot more women coming into this year's class, people had mixed feelings. The guys were saying, 'Oh, that's nice! Some more female faces.' They were kind of putting on like they enjoyed it. But others were a little bit resentful, you could tell. It's really a male-dominated thing, you know, the whole fraternity scene. But, the three of us, there really hasn't been any problem, because I really think it's sort of like, we're just tokens here, I guess, and we're not threatening. And it's something that they can go home and brag, like, 'Oh,*

we have three women in our class.' Like it's a big deal to be proud of. (Third year student, female)

But another woman expressed the common view that the men actively resent the women students and think they are taking a man's place:

That's very, you know, the biggest source of aggravation for the new female students is the male students who essentially resent their presence; who feel that they're taking a man's place, that they're unfair competition. I've been very careful about that, to the point of being almost paranoid, but I think it is going to be difficult for new women. (Second year student, female)

A third woman felt that this resentment is so strong that the men refuse to give them credit for their accomplishments or to take their professional commitment seriously:

What bothers me is that I get excellent grades, but the men treat it like a joke. If you work hard, guys ask why. You have to prove your competence and commitment daily, and, even then, people just cannot believe that you are actually going to practice your profession. I guess it wouldn't be so blatant and stereotyped if there were more women out there. (Third year student, female)

About their fellow women students, the women were quite consistent in their feelings that there were too few of them in a class to matter. One woman put it best when she said:

There are only three of us in my class, and we are as different as can be. We found out early that we didn't share the same interests and have never been friendly. The lower classes have more women, and it is clear friends can be made, but for us, we were just too few and too different to ever get along. (Second year student, female)

These sentiments were pretty generally shared.

The men had some interesting things to say about the women. It should be noted that some tended to echo sentiments about what "women in general" or "women in podiatry" do or have done rather than speak specifically about their individual female classmates. While this was not always the case, we did hear statements like:

It's all very well and good to have women here, but I question whether they will practice. (Third year student, male)

It is also interesting to note that men in podiatry tended to question the competence of the women in their classes more, it seemed to us, than in medicine, for example. In fact, the women do equally as well and often better as a group than do the men. When confronted with this fact, one man responded:

I don't doubt they don't get good grades. Of course, they use their feminine wiles. (Second year student, male)

Lest the reader get the impression that the relationships between students at the schools were less than amiable, the following quotes should change that:

Somthing happened recently which made me feel good. It was our first day in class and the instructor made this announcement: 'I want to know where the women are. Where are the women? Raise your hands.' And he asked each of us questions, and put us on the spot, told us that we had no right being there. He said, 'I want you to know from the beginning how I feel about this. You should be home having babies.' Then he went ha-ha. But the class didn't laugh. Everybody felt uncomfortable. And I was glad that they didn't laugh. Maybe if we were freshmen, they would have. There was some real support shown there. I talked to a lot of people afterwards. They came up to me and said, 'I really felt embarrassed. Not just for you, but I just felt embarrassed for us all. It was dumb. It wasn't necessary.' (Second year student, female)

I feel that I have had a positive influence on a lot of my classmates. Like, the last day of school, after the final exams, we usually all go out and get smashed at the local bar and, it was funny, we got together and we were all drinking and I don't know how many guys came up to me, the type of thing when nobody else was looking, they had a few drinks under their belt, and said, 'I really want to thank you. You've really shown me that there are different types of women in the world. I really had a stereotype until I met someone like you.' That sort of thing does come out. I know it does come out to the other women in the class also and so it's a good feeling. It's something, I guess that maybe they don't talk about it openly, maybe they do now. But some of the married guys have said this, that they are relating to their wives differently, better. You know, just having a few discussions with me and talking women's rights and roles. (Third year student, female)

The most consistent and far-reaching problem that women have with their male peers and vice versa revolves around sexuality, and the ambivalent feelings that apparently surround these relationships. Podiatry is no different from other professions in this regard, but the fact that there are so few women tends to magnify the problem for them. The following are examples of the problems of sexuality:

> *In the beginning after I got to know some people, I did some dating. It was because I was single and I wasn't obligated to anyone and so I dated, but then all of a sudden I became, I don't know if it was a sex object or just a girl that they could date until they met others here. But they needed women and so then all of a sudden I found I was just getting smothered by the men because I left myself open. And then they became very—I don't know if it's here because there are no women, but they got attached very quickly. They're very possessive, very fast, and I think a lot of it was competition and all that between men, but it sort of became rough. About the next two months I was really unhappy because it was almost like too much. It got really rough and I had to cut out everything, just all relationships with the guys, no more dating with anybody because I felt I was just an outlet for these guys and I wasn't being a student, at least respected like a student. (Third year student, female)*

Another female had this experience:

> *Well, the one thing that I've done personally is I've made it a point not to flirt; I don't do that. I don't want people hating me. You know, that's the last thing I need. (Third year student, female)*

She also observed:

> *I'm married, but two of the women in my class are single. And I can imagine if I were single and if it were a 50:50 situation in numbers, and if I wanted to date somebody in the class, I could probably get away with it without being noticed too much, because there would be a lot of dating going on. But when you're just three percent of the class, if you date anybody in that class, if you have any sort of a relationship, it would be all over by Monday morning. Everybody would know about it. So you have to contend with that. I'm sure that the women who are single here have to be very careful about any dating. They probably have to date outside the school. (Third year student, female)*

This fact about social spotlighting was echoed by a second year female:

> *Everybody knows everything about all the women. The rumors are just incredible, and they're not necessarily true. Well, for example, I must have been here three days and the entire*

school knew my name. That sort of thing, like you don't remember anybody else's name, but like they remember yours because you're the oddball. (Second year student, female)

Our study found that men also had problems with the women. The general sentiments of the men were perhaps portrayed best by this second year student:

I know it is stupid, but I just do not know how to relate to them. There were women in college, many women, but that is perhaps the problem. There are so few of them, and everyone seems to be mooning over them that you sort of fall in line. I hardly know one woman in the third year class, and I am extremely attracted to her, I just don't know. (Second year student, male)

It is quite possible that the fact that there are so few women in podiatry, that they are such oddities, that creates special problems for both the men and the women in carrying on any purely professional relationship. Ambivalence abounds, even for the "relatively safe" married students. It is a problem which evidently isn't spoken of much, but which causes real anxieties for men and women alike.

Experiences in Training

While all students agree that the rigors of podiatry school are difficult and challenging, the women seem to face some problems from these experiences that the men do not. Some of these problems have been mentioned above such as being spotlighted and being considered tokens or mascots rather than committed professionals. In short, women in podiatry face the same kinds of little day-to-day incidents that women in all of the MODVOPPP professions face. Each woman has had some unpleasant experiences--from being humiliated by a lecturer to being neglected by a clinician or taunted by a classmate. However, women in the podiatry schools we visited often felt that they were better off than women at other places they know of and that the men in their schools were making an effort:

I know we have problems, but it doesn't appear to be as bad as what other women are complaining about in their medical schools. Latent discrimination where in the classroom, in anatomy class for instance, this has happened to a couple of different schools in different parts of the country, the same instance was referred to where a professor was showing slides in anatomy and then had a Playboy bunny or pin-up in there so everybody could have a laugh. We don't have any of that happening here. I think part of the reason is we have mainly women in our Basic Science faculty. (Third year student, female)

And:

> *I haven't experienced any problems from being a woman from the school, and I thought I would. I have heard that the administration has cracked down on that sort of thing. (First year student, female)*

In fact, one of the schools has become sensitive to this issue. As one administrator put it:

> *I am against special rules for men and women, but I do recognize the problem women face at an institution like this, so I usually try to get together with them as a group once or twice just to find out what kinds of problems they're facing in the institution. I haven't gotten together this year with them, but I did last year with at least one or two of the female faculty members... just to discuss with them what it's like to be in a predominantly male institution and environment. (Administrator, male)*

He revealed that some things have been done to sensitize people to the issues of sex-biased behavior:

> *Well, I do it and I do it many times on an individual basis. As a matter of fact, we had a committee meeting yesterday, and I was upset with the approach of one of our clinicians and I have a luncheon engagement with him tomorrow at noon time and we're going to talk about it. So, many times I'll do it on an individual basis. The institution is small enough so that I can do it Last year in one case, one of the women applicants came in, and she was quite attractive, and she started out the door and one clinician (in jest, I'm sure more than anything else) said something to the effect that, 'Well, honey, keep your back straight and you'll get in.' Well, not only did he get it from his peers, but the gal, thank goodness, came back and mentioned it to us. I also discussed it with him within the day after it happened. Before he was assigned to do duty this year, it was discussed again and I would say that he felt pretty bad. I wasn't going to take him off the committee because of it, because again, when you talk about sensitizing, well, we're out to sensitize, but not to destroy. (Administrator, male)*

While conditions are somewhat improved over the past, many women feel that there is still quite some way to go:

> *A lot of those men, faculty and students, don't want us here. A lot of them don't think we can make it and most of the guys in my class feel that I can't make it even this far. I feel I've got to show them. And the committee, when they take us on, they say: 'Well, we haven't done too well with the women in the past, they quit on us.' They say, 'Well, we had three women in one class and only one graduated. The other two got married and left.' And*

they emphasize to you when women haven't made it, and they brought out something about a study about how women have gone through med school and how they were not in practice and how many were housewives. And they said, 'We really have to have this feeling that you are going to go all the way through.' So because of this, when you come in, you just feel the whole time you're here that you have to prove yourself to them. You have to prove to them: 'I'm serious and I'm gonna make it.' (Third year student, female)

Or, another woman's complaint:

There were a few gripes I had last year as a first-year student. For instance, in gross anatomy class the female reproductive system wasn't taught. It was just skipped. There was a professor involved, who, well, he's an anatomy professor so he knows, he's supposed to know what he's talking about, but he couldn't handle, he couldn't deal with it, having a mixed class, I guess. He couldn't and that surprised me. (Second year student, female)

She also posed an interesting analogy about the relative legitimacy of sex-biased behavior:

In the classroom it's not cool to be a racist, but it's still cool, in some senses, to be a sexist. They can still get away with that. And in my mind, you know, like I just, I confronted one professor about singling out the women in the class, I said, 'Would you have done that with Blacks?' He wouldn't have had the nerve. He wouldn't dare. 'Would you have done that with Jews?' Heaven forbid. That would be, that would be disgusting. But to do it with women, it's cute. That's the only way I can make the point to these people sometimes because they feel that they have a handle on their racism. Even if you are a racist, you certainly don't express it in today's society if you're an educated person. You know better and it's frowned on socially. But sexism you can still get away with.

Attributes of Students as Viewed by Faculty and Administrators

The administrations and faculties of the schools visited during the study were consistent in their praise of students. As one professor put it:

I have seen dramatic changes in the students over the past few years. For one thing, they're older. They seem more directed, motivated, serious if you will. For another, they are much brighter than in past years. They are almost all graduates, some with advanced degrees. They all bring high credentials and the fact that our attrition rate has dropped bears this out. (Faculty, male)

One problem apparently remains, however, as one administrator related it:

> *It is unfortunate that the students are forced to be so competitive. Getting in is not enough. Students must also do well to favorably compete for residencies, and, with more and more students wanting residencies, the problem becomes more and more critical. Unfortunately, the worst fallout of this situation I am sorry to say, is some unethical behavior. The students will talk of it, I am sure. It is almost impossible to run a test on the honor system. Students, and it is not all, just some, tend to cheat if they aren't closely watched. It is unfortunate not only for them, but their classmates and the profession as well. (Administrator, male)*

One administrator saw the problem as one of unfulfilled expectations. In his words:

> *The attitude of students toward most professional institutions is absolutely atrocious. I think the students come in expecting to be treated as professionals, they expect all the professors to be absolutely superb at this level. They expect that there will be no problems. The problems of undergraduate and high school are all over with now...now we're going to really get the education. And of course, it's quite a trauma for them to find out that things are only a little bit different from what they've been through already. I'm of the mind that there is no reason why there has to be a constant crisis, why there have to be constant battles between professors and students, or why students have to be treated less than professional. Because, when they are treated as children, forced to compete as they always have, they are going to chafe at the bit. We are trying to do something about it, but we are not within a vacuum--there are other institutions and programs involved. (Administrator, male)*

When the professionals are asked to comment on the female students, some interesting patterns emerge. First, women are never singled out as persons who cheat on exams as men sometimes are, but other forms of behavior are observed. One younger faculty member believed "the women constantly play up to you to get good reports, or so it seems."

A second consistent concern of faculty and/or administration is whether the women will practice once they graduate. "I just hope they do not get pregnant and quit," or the more despairing, "I know, they will not practice. It is like wasting a space" are common statements. There are no recent figures to indicate just how many women do or do not practice or why. It appears, however, that these assumptions about women's activity levels are also held in the other MODVOPPP professions.

A third concern is not for the women in school, but for women in practice. A common opinion voiced is, "no matter how competent a woman is, and some of the girls here are crackerjacks, I still think she is going to have problems with public acceptance."

Not all of the comments about women are negative. On the contrary, many positive statements were made about women in podiatry, including:

> *Podiatry is a wonderful profession for a woman. It is not life and death, and she can set her own hours and still raise a family. (Clinical faculty, male)*
>
> *I don't know if this is true, but the women seem more dedicated, and I don't mean money conscious, some of them I feel will be better practitioners because of their empathy and concern. (Administrator, male)*
>
> *The women are the best students in my class. (Pre-clinical faculty, male)*

Attitudes and Expectations About Practice

Partly because the education is rigorous and very expensive, partly because podiatry students are often not afforded the status of other health professional students, partly because podiatry is relatively unknown, and partly because of the limits of traditional solo practice, podiatry students seem to be highly concerned with making money when they graduate. Often a means of legitimizing the profession to someone is accomplished by relating how much money can be made. The women in the study often were quite vocal in their condemnation of what they felt was the male students obsession with money.

Some statements of the women about practice or postgraduate anxieties included:

> *I don't know if it's a real or just imagined difficulty I have, but I would think that, you know, someone would hesitate to invite me into a practice or I just might be skipped over because I am female. I don't know if that's the case or not. (Second year student, female)*

Another opposite sentiment was also expressed:

> *So many people are opening up for women because they want to give women's lib a chance. And it's really strange now that people work out this way because there are so few women, that I can guarantee you that all the girls sitting around this table would get a residency if they want. Because everybody is ready*

> *to open their doors to women. Not everybody, totally, there are some individuals who are really horrible, but I just think that there is a lot more opportunity for women it's very obvious. And they've never been shunned actually, in the podiatry profession. (Fourth year student, female)*

One third-year female, from another school, had this chilling observation, about the above sentiment:

> *In a way, I am not anticipating any problems (in getting a residency) because we're a minority and you have to take minorities. It's almost a must. Everybody nowadays, whether it's a job or anything, is taking minorities. So I have a feeling when we women graduate, there's gonna be--I think there's five girls behind us--so that is seven or eight are gonna be graduating and I think they're gonna take at least one, maybe two of us. I have this feeling. We will all get residencies this time. But in the future, when more women are graduating, it may get harder. Sure, they will take them, token one or two in a program of eight, but after that, forget it, no matter if you're better than all the men. They will never take a majority of women, even if women were the best. (Third year student, female)*

It should be said that none of the students interviewed was overly concerned about practice. As a group, they represented probably the most confident of the MODVOPPP students with regard to their practice opportunities.

VI. SUMMARY AND CONCLUSIONS: IMPLICATIONS FOR WOMEN IN PODIATRY

As much of the report has suggested, the profession of podiatry is going through a period of rapid growth, change, upgrading, and expansion, as can probably be said for all of the MODVOPPP professions. In 1980, podiatry practice responsibilities, alternatives, and problems will be quite different than they are today. However, because of podiatry's apparent growth and expansion, the changes in the profession may turn out to be among the most dramatic of the MODVOPPPs. What this obviously means for women, as for all students, is that they can be involved at the beginning of an interesting series of changes in what is a relatively young profession.

Much of what will happen for women depends on the commitment of the schools and the profession to increase the numbers of women in podiatry. If drastic changes are not made, the percentage of women will drop appreciably over the next few years due to death and retirement.

If any commitments are made to increase female enrollment over the existing meager levels, problems may ensue due to the resistance of faculty, students, and alumni. Informants to this study have suggested that such resistance has already begun to surface. This is true regardless of the fact that women are more significantly represented in all the other MODVOPPP schools.

In podiatry where the demand for postgraduate residencies is far greater than the supply of available positions, increases in the number of women in the schools will produce animosities if the added dimension of sex becomes important in residency program selection procedures.

The recent growth in the demand for residencies has brought about other growing pains. These include the obvious ones of non-objective criteria or favoritism in selection procedures and exploitation of selected residents. More subtle, and perhaps more damaging, is the competition which the situation fosters, the unethical practices (including cheating) that it breeds, and the dismayed and disappointed students who are often its victims.

There is a shortage of female clinicians in podiatry. The women podiatry students mention the lack of role models in podiatry. There should be some attempts made to improve the situation.

Podiatry has established itself as one of the primary health professions. All indications are that podiatrists will share in any and all health care delivery system changes fostered by the federal government. At the same time, the profession hopefully will become more responsible for sharing its benefits with all of its members. In this regard women must be given the opportunity and incentive to become active in all elements of professional practice.

The recent growth in podiatric education has out-distanced the record keeping and data analysis activities of the profession. The introduction of the new centralized application sources for school admissions (AACPMAS) and residency placement (CASPR) provides an opportunity for a more refined and complete system of record keeping and data analysis.

VII. SPECIAL RECOMMENDATIONS

FOR THE PROFESSIONAL ASSOCIATIONS

The APA and the AACPM should recognize and acknowledge the need to expand the numbers of women in the profession. If a general statement of intent is agreed upon and widely disseminated, this will be a clear indication to qualified women that the profession needs them. In this regard, some effort should be made to acknowledge the comtribution that women have made to poditry, and some effort should be made to encourage the profession as a whole (including practitioners, schools, and students) to accept the women it is training.

In order to protect against any future decrease in qualified applicants due both to shifts in undergraduate student preference and overall decreases in college enrollments, the profession should begin now to improve upon its profession-wide recruitment efforts. Whenever possible, women podiatrists, faculty members, and students should be involved in designing and conducting the profession's recruiting efforts to insure that women will be represented now and in the future. Moreover, in order to overcome the imbalance in female representation in podiatry that is sure to occur over the next few years, aggressive recruitment efforts should be begun and sustained to attract more women into the profession.

The APA, CPE, and AACPM must do something about the residency program supply crisis. What is needed is a coordinated effort on the part of the schools, the state societies, and the individual practitioners and students within the profession. The recently established CASPR program could be the focal point for this effort. Care should be given not only to residency generation, but also residency selection and resident treatment.

These efforts should recognize and appreciate the problems that women have in receiving equal experiences and services in the postgraduate environment in housing, dressing facilities, and treatment. Moreover, they should be sensitive to the fact that the acceptance into residency programs of the small number of women now graduating from podiatry school is no indication that women will not face problems in securing residencies as their numbers increase in the schools. The responsible elements of the profession should recognize that there will be resistance to any marked increases in the number of women in podiatry.

The AACPMAS and CASPR should keep records by sex of characteristics of the total applicant pool and should include such variables in periodic data analyses as:

- undergraduate majors
- overall GPAs--in sciences--in non-sciences
- aptitude test scores--individual parts, overall
- number and sources of letters of recommendation--that is, undergraduate instructor, family physician, and so on
- practitioners in immediate, extended family
- prior related experience in, exposure to the profession
- interviewer(s)
- prior work experience--amount and type

Records should be monitored and analyzed by schools and by appropriate agencies to identify any patterns and biases (especially unknown and unintended ones) working against women and minorities--for example, certain interviewers tending to screen out women and minorities proportionately more often or higher acceptance rates of applicants having letters of recommendation from important practitioners in the profession (active members or officers of local professional associations, for example). In this way the services will provide assistance to the profession in its overall efforts to establish and maintain equality of access and practice.

FOR THE SCHOOLS

The chief administrators (presidents and deans) of the schools of podiatric medicine should endeavor to set a tone and atmosphere at their institutions that promotes cooperation between faculty, student body, and administration. To this end, they should endeavor to give clear and positive messages that women are welcome at the school and within the profession. Such statements may be useful in curtailing the expression of negative attitudes and uncomfortable behaviors that women experience.

Schools should step up their recruitment activities to attract more qualified women into the profession and to replace the women who will soon be lost through retirement and death. These activities should be coordinated through the admissions offices and should include the participation of male and female practitioners and alumni, students, faculty, and administrators.

Efforts should be made to contact women within undergraduate pre-med programs and to introduce them to the benefits of podiatry. Such a campaign should ideally make clear the message that women are welcome in the profession while at the same time assuming or recognizing their diversity of interest and ambition and portraying the many opportunities a podiatrist has to practice. This portrayal could include discussion of the recent trends in podiatry away from solo and toward partnerships and group practice and could also note the increasing opportunities for podiatrists to obtain residencies and hospital privileges.

Mechanisms should be established at the schools of podiatric medicine to enable the women in attendance to identify their problems and to discuss them with the authorities in the institutions who can address them. Basically, the schools should recognize that the experiences of female students differ in several important respects from those of their male colleagues in the schools of podiatric medicine.

Also, some means of resolving grievances should be provided. Where possible, insensitive or discriminating faculty, administrators, or students should be provided assistance in understanding and appreciating the negative impact of their attitudes on women. Moreover, all people in the institutions should be made aware of the unique problems that women face in attending schools of podiatric medicine.

The schools should recognize the problems created by the podiatric residency supply shortage and should move to resolve them. First, students should be provided with adequate information about residencies and knowledgeable faculty and administrators should be available for consultation around residency selection issues. If the school does not take some responsibility to assist

its students in their postgraduate aspirations, it will in some ways promote and sustain an informal network of favoritism which rewards "contracts over competence." Women are often at a disadvantage within such systems.

Also, the schools should expand their current efforts to generate additional residency programs. In doing so, the schools should work together with the associations, state societies, and alumni in a coordinated and cooperative effort.

Schools should try to discourage the destructive competition that is a direct result of the residency supply shortage. What is needed is a cooperative effort between the school and its students. Such efforts are time consuming but rewarding.

In order to combat the sex-typed image of the profession, the schools should attempt to attract more female clinical faculty and should attempt to make these women more visible within the profession and the school. Because the supply of available female clinicians is low, certain approaches can be taken now to provide for future results:

- women students should be encouraged to consider an academic career in podiatric medicine (the practice patterns of women suggest that they may be more likely to accept such academic appointments than their male counterparts);
- women should be hired for pre-clinical positions since women in these fields are not in such short supply;
- women administrators should be hired since they too are not in such short supply;
- women should be assigned to visible positions on committees such as admissions, faculty search, or faculty affairs to provide them with more exposure in the profession.

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APPENDIX A

SUMMARY OF INDIVIDUAL AND GROUP INTERVIEWS NUMBER OF SCHOOLS VISITED, AND OTHER CONTACTS WITH THE PODIATRY PROFESSION

A. NUMBER OF SCHOOLS VISITED: Two

B. BREAKDOWN OF INDIVIDUAL INTERVIEWS:

	Male	Female	Total
Administrators			
1. Deans, presidents, chancellors	2	-	2
2. Assistant or associate dean	3	1	4
3. Affirmative action officers	1	-	1
4. Other administrators	1	2	3
TOTAL	7	3	10
Faculty			
1. Pre-Clinical	3	10	13
2. Clinical	5	1	6
TOTAL	8	11	19
Students			
1. First year	-	1	1
2. Second year	-	2	2
3. Third year	1	2	3
4. Fourth year	4	2	6
TOTAL	5	7	12
GRAND TOTAL	21	20	32
C. GROUP INTERVIEWS	7	14	21

D. OTHER CONTACTS

1. Discussions with American Association of Colleges of Podiatric Medicine (AACPM), June 1975 and January 1976

2. Discussions with American Podiatry Association Council on Podiatry Education, June 1975

3. Presentations:

   AACPM Annual Conference Presentation, August 1975
   Article - "HEW Exploratory Study of Women in the Health Professions Schools" Journal of Podiatric Medical Education, Volume 6, #3, Fall 1975, pages 12-25

APPENDIX B

SUMMARY OF PROFESSIONAL ASSOCIATIONS

American Podiatry Association (APA)

The American Podiatry Association is the primary professional body in podiatry. Founded in 1912 as the National Association of Chiropodists, the APA has promoted the interests of podiatry for over 60 years. The APA is located in Washington, D.C. It is run by an 11 member Board of Trustees and a House of Delegates. Administrative duties are carried on by a full executive staff. The APA publishes the Journal of the American Podiatry Association monthly.

American Association of Colleges of Podiatric Medicine (AACPM).

The AACPM, made up of the schools of podiatric medicine, is located in the American Podiatry Association Building in Washington, DC. Since 1967, the Association has been the coordinated voice of the podiatric medical education system. As such, the Association publishes a journal four times a year; directs and sponsors the CPAT, the aptitude test required of every applicant; operates AACPMAS, the service which coordinates the podiatry school application process; directs the Central Application Service for Podiatric Residencies, CASPR, which coordinates the post-graduate podiatry residency system; and promotes the interests of the profession and the schools of podiatry to the public, Congress, and where necessary, the Courts.

Council on Podiatry Education of the American Podiatry Association (CPE).

The CPE is the recognized accrediting body for the profession of podiatry. As such, the CPE monitors the curriculum, atmosphere, and performance of the individual schools, reviews and approves the residency programs established for Doctors of Podiatric Medicine, and accredits the existing program for podiatric assistants, podiatry's auxiliary allied profession. The CPE is also located in the headquarters of the APA.

Residency Genesis Committee of the APA.

The Residency Genesis Committee was formed to expand the supply of residencies available to graduating DPMs. Together with the schools, the CPE, the AACPM, and the Residency Genesis Committee of the American Podiatric Students Association (APSA), the Committee has endeavored to increase that supply. As mentioned throughout this report, those efforts have not been entirely successful, and future efforts may require a more formalized process.

American Podiatry Students' Association (APSA).

The American Podiatry Students' Association is the small but active political arm of podiatry students. The group has established relationships with other MODVOPPP student groups such as the Students Osteopathic Medical Association, but because of its relatively small size and obvious students focus, the association has not had a great impact on the profession.

APPENDIX C

SUMMARY OF STUDENT GROUP INTERVIEW ISSUES REGARDING PROFESSIONAL TRAINING

INTRODUCTION

URSA used two primary techniques for interviewing students about their professional training experiences in general and about the problems they encounter in gaining access to and pursuing professional training in particular. Each produced a different set of issues and different emphases.

URSA adapted a planning technique known as the Delbecq Nominal Group Process into a form of group interview which we used to surface from groups of students a broad spectrum of problems and issues they encounter in professional training. The groups were small--typically numbering less than twelve--and they included all female groups, mixed male/female groups, and all male groups. The group interviews gave us insights into which of the problems most group members shared, which seemed to present the greatest obstacles in professional training, and which are controversial.

URSA also conducted a series of individual one-on-one interviews with male and female students. The individual interviews often touched on problems and issues not raised in the group interviews because they might be considered "too personal", because they needed direct probes and encouragement to surface, because they were not shared by other members in the group, or because they were not directly related to the question the group was asked to address.

The list of problems included in this Appendix and the analysis which precedes it represent only those issues raised in group interviews by students in response to a single question posited them by the URSA field team. The list does not include any additional issues--and there were many--which surfaced in individual interviews.

As the study progressed, URSA used several questions in the group interviews, changing them to allow us to probe or follow new areas of concern. As most were non-productive (see VOLUME I on Methodology), this Appendix includes only responses to the question: "Given your experiences and observations, what problems does a woman encounter in becoming an X (doctor, dentist, etc.)?" for women, "Given your experiences and observations, what problems does a person encounter becoming an X?" for mixed groups, and "...what problems does a man encounter in becoming an X?" for the men.

Group members were given approximately ten minutes to write their responses to the question on a card, and the answers were recorded without discussion on easel pads so that all members of the group could see the responses. The list of problem categories included and discussed below was generated from the responses on these cards and on the easel pads. In most cases different issues were raised by men and women, but in all cases where the problem category was shared, it was discussed in different contexts, with different emphases, and in terms of a differential impact on men and women.

Generally the problems mentioned clustered into six categories: structural features of the school(s), profession(s), or sex roles; absence or inadequacy of programs, services, facilities, or equipment provided by the training institutions; problems with characteristics of the profession and its work; access to resources required to consider the profession, be admitted to school, and to participate fully in professional practice; negative attitudes and behaviors of peers, faculty, practitioners, and clients; and the impact on oneself of all of the above.

STRUCTURAL FEATURES OF THE SCHOOL(S), PROFESSION(S), OR SEX ROLES

This category includes all those structural features of the profession or school that affect women's experiences in training as well as structural consequences of societal sex roles which reflect the society's assumptions about appropriate roles for men and for women. By appropriate roles we mean those behaviors, feelings, attitudes, skills, attributes, characteristics, and motivations we usually associate with one sex to a greater extent and/or more often than with the other. Structurally, for women, this refers to the specific sets of responsibilities delegated to them by the society on the basis of their gender. Issues raised by women students in this category include:

Lack of Role Models

Basically this is an issue of how many and where women faculty appear in the schools. At some schools the problem is that there are no women faculty or clinicians at all to whom female students can look for evidence that a woman "can do it." In other schools, women appear only in what students consider the lesser status positions (e.g., Basic Science Instructors) which women students feel is a statement about a woman's proper role within the profession. At the few schools in which women clinicians appear in high level positions, some female students may reject them as unacceptable role models because the women have not managed to balance professional success in filling other feminine roles.

Lack of a Support Group of Women

Women students hope and sometimes expect that support from other women will help offset the social and professional isolation they feel in the male environment of the professional schools. The lack of such support is a severe disappointment and often aggravates the pressures of loneliness and isolation. This is a direct result of few numbers of women in a class or school and is compounded by differences in age and marital status.

Being Tracked into a Limited Range of Specialties or Practice Opportunities

This problem has two aspects. Certain specialties and practice options in each of the professions are labeled as more or less appropriate for women. To some degree these labels are consistent with commonly held stereotypes regarding women in this society. For example, the specialties involving work with children are all considered appropriate for women. Similarly, regarding practice options, those that involve supervising a staff and running a business are generally regarded inappropriate for women. For most women in making the decision regarding specialty selection or practice choice, the stereotypes and pressures to go into one rather than another

selection are important. More important, though, are those problems arising from the necessities in a woman's life of carrying responsibility for both a family and a profession. This consideration, and at times necessity, works to track women into those specialties or practice options that are most easily controlled in terms of numbers of hours worked.

Balancing Work/Family

The years of professional training coincide in our society with a woman's childbearing years. To the extent that women are primarily responsible for the home and children, the problems of time management, energy commitment and sheer logistics in being a full-time student and committed practitioner and wife/mother at the same time create a tremendous pressure and problem for women that men do not experience. This is the single most widespread, cross-professional issue of which women spoke. If the women were not already in the position of managing both wife/mother and professional (student) roles, they anticipated that they would in the future.

Women at a Disadvantage Due to Background or Physical Ability

In some professions women feel that they have a distinct disability or handicap due to their background and socialization as women or due to physical size. In dentistry, for example, a familiarity with tool use and terminology is important and often assumed by the schools. Many women spoke of the problems they encountered in picking up such skills and information that the schools assumed they had but didn't (and that many male students did, in fact, have). In other professions where physical size and strength are important, women spoke of the difficulties and inequities in trying to learn techniques that were developed for the male physique.

Social Problems: Fear of the Impossibility of Finding a Mate

Women in all the MODVOPPP professions speak of some problems with dating men who do not understand, support, or accept their choice of a male profession. In medicine women speak of the fear of never finding a male who could accept their high status, high pay, and strong professional commitment. This problem is uniquely women's because it is an accepted pattern in our society for men to marry women who have less social status and less earning power than they. For women in professions with top status and pay, the range of men for whom they make appropriate matches tends to be limited to the men within the profession who might be more successful than they.

ABSENCE OR INADEQUACY OF PROGRAMS, SERVICES, FACILITIES, EQUIPMENT AND OTHER SUPPORTS OR RESOURCES

When schools fail to provide, or provide inadequate, resources in the learning environment and training program, difficulties are caused for women. This becomes an issue when their special or equal needs are not met by the physical plant. For example, when uniforms, lab coats, surgical gowns, etc., are not available in women's sizes women have to wear things too big for them or dress in the uniforms of other health professionals (such as clerks in pharmacies, nurses in surgery). Changing rooms, lounges, women's toilets, and on-call sleeping facilities are often not as available and accessible to women as to men. Health care services or insurance often do not

cover gynecological and family planning services. Child care is not available. Escort services are not available for women working late in labs, clinics, or libraries.

CHARACTERISTICS OF THE PROFESSION AND ITS WORK

Issues in this category were only mentioned by male students. The category includes features of the work or of the profession which create a pressure on the student and on the practitioner. For example, the life or death responsibility of a physician is felt heavily by medical (both MD and DO) students who feel a special necessity for learning everything possible while in training, for developing emotional means of dealing with that responsibility, and for demanding a more than full-time dedication and commitment from themselves and their peers. An issue more widespread among the MODVOPPP professions has to do with the relative status of a profession vis-à-vis the medical profession. Particularly in the lesser known professions that are struggling with the medical profession for recognition and control over practice rights, the lower status is seen by male students to be a large obstacle to public acceptance.

ABSENCE OF OR DIFFICULTY IN GAINING ACCESS TO RESOURCES REQUIRED TO CONSIDER PROFESSION, BE ADMITTED TO SCHOOLS, OR ESTABLISH FULL PROFESSIONAL PRACTICE

Lack of Encouragement and/or Information

Given the rigors of training and the added pressures for women in a male profession, institutional and informal supports are vital. Women feel a lack of encouragement and support and at times experience direct discouragement. Particularly in the decision to pursue a profession the amount and extent of information and encouragement given women is vital. Although men spoke of a lack of information as an issue for them in the lesser known MODVOPPP professions, it is even more difficult for women. A related issue is access to information passed along informal networks that do not include women--e.g., fraternities, golfing partners, etc., giving helpful hints or suggestions for "how to get what you want" peculiar to the profession.

Access to the Profession's Informal Network of Practitioners

Women experience problems in this area both in training and when trying to obtain access to internships, residencies, or jobs. While in training, women report they are left out of the informal male network in which information is exchanged, support given, and friendships formed. These settings include fraternities, men's changing rooms, golf, and other athletic teams. Women worry that this will result in being left outside the referral and job network when they become practitioners. All students, male and female, worry about getting jobs, internships, and residencies. Women devote much of their energy in this regard to figuring out how to deal with the well-documented and well-known prejudices against women held by practitioners. This increases the pressure on women to "prove" themselves, reinforces the feeling that they aren't welcome in the profession, and most importantly, represents a real obstacle to women in getting through training and into professional practice. Jobs passed from fraternity brother to fraternity

brother, practitioners relying on informal recommendations from their friends regarding which applicants to accept to their practice, and prejudices about the abilities and competencies of women all result in important limits on women's access to these positions.

Absence of Appropriate Personal Characteristics and Attributes Required of Students, Practitioners

This problem was expressed in resentments and statements made by male students in their group interviews and by women in terms of the main stereotypes which the women feel are used to challenge their presence in the schools and in the professions. Frequently mentioned stereotypes include: "women are too emotional", "women are only accepted because they are women", "women are less dedicated", "women are only here to prove something", "women are not good at analytical thinking", "women are too indecisive to be good managers".

Absence of, Concern about Ability to Meet Formal Requirements of Students, Practitioners

This category of issues was mentioned only by men in most professions. It was expressed as concern about passing courses, passing the National Licensing Boards, etc.

Access to Financing

The financial burden of training is felt by both male and female students, but it is expressed to a different degree and in different contexts. For women it is harder to earn money before and while in training. The jobs available to women often pay less money, and in some professions where jobs are available to the untrained (e.g., veterinary clinic assistant), women are not given the jobs. While in training women report they believe it is more difficult for women to get adequate loans. Parents are often less willing to support a woman than a man through expensive and long training. Spouses are less often available as a source of support for women.

NEGATIVE ATTITUDES AND BEHAVIORS OF OTHERS

This category includes the constellation of attitudes, reactions, and behaviors which women face daily in the training environment.

Incidents of Sexism in the School

We heard many and various reports of jokes at the expense of women--e.g., denigrating comments, nudie slides in lectures, actions or comments aimed at embarassing or "putting down" women, intentional or unintentional use of language in such a way as to ignore or put down women. The majority of these incidents were performed by male peers or male faculty.

Resentments by Male Peers

This resentment is primarily expressed by male students in regard to competitive situations in the profession. For example, it includes resentments that women in school are taking a man's place, that women getting jobs means less for men. It also includes beliefs that women get special treatment by admissions committees, faculty members, and clinicians. Another source of resentment from male peers regards the amount of sexuality that is regarded

as appropriate in women. At some schools males express disapproval of the women for stepping outside the boundaries of a traditional woman's role, thus in some way challenging their own assumptions about and ways of dealing with women.

Client Prejudices

This category includes both real and anticipated problems with patient disbelief, distrust, and sometimes refusal to be treated by a female practitioner. The result of these prejudices is that while in training women may be denied important learning opportunities, whil in practice it may be more difficult for them to get patients, and in all cases they must anticipate the necessity of proving their competence.

The Prejudices of Staff and Employees in Clinic Settings

In the professions that include a business or managerial component, prejudices and unwillingness of employees and staff to be supervised by a woman is particularly difficult. In all the professions, respect and acceptance as a professional by other health workers is essential. Women report that respect and acceptance are denied them because of their gender.

THE IMPACT ON ONESELF OF STRUCTURAL FEATURES, THE ATTITUDES, AND BEHAVIORS OF OTHERS, OF THE TRAINING PROCESS ITSELF

All of the above listed problems mentioned by women have some impact on their own feelings about themselves and their profession, on the choices they make, and on their behaviors.

Women's Double Binds

This category was variously described by women as "walking a very thin line", "damned if you do, damned if you don't", and "you can't win as a woman and as a professional." Standards of professional behavior conflict with standards of feminine behavior and women are caught in the middle, particularly in situations requiring aggressiveness, decisiveness, or managing others.

Women's Feeling That They Must Work Harder to Prove Themselves

The combined pressures and impact on women of stereotypes that challenge women's abilities, competencies and commitments result in women reporting the following kinds of problems: women fear making mistakes or taking risks; they fear speaking up or asking questions that might be considered stupid; they feel they have to work twice as hard to be recognized by faculty; women feel reluctant or unable to ask for any special support or help out of fear that the request would reinforce negative stereotypes about women.

Problems with Maintaining Relationships/Other Interests

This has most to do with the emotional strain, academic time pressures, and isolation of being a health profession student. Both male and female students feel cut off from friends not in training with them, and they experience problems in finding energy to devote to significant relationships and in lack of time to spend on other interests. While these problems were mentioned with equal emphasis by both men and women, for women the problems of isolation and being cut off from people outside of the training experience increases the difficulties they experience of being isolated within the training environment, too.

Competition and Academic Pressures

Only male students have expressed this as a concern in each profession, and it appears to be a central problem for them.

Feeling You Must Turn Off Your Emotions

Although related to double binds for women where expressing emotion is considered inappropriate as professional behavior, this is a specific issue that was raised by both men and women. Professional conduct and the pressures of dealing with many cases in a small amount of time demands a certain distancing on the part of the practitioner. Women and some men take issue with these demands because they feel it cuts off a part of them that is (and in their minds, should be) a part of their medical involvement.

Concern That The Training Process "Changes Who You Are"

Again, a concern shared by male and female students, this relates to all the ways in which they feel the professionalization process demands conformity to a single model of professional conduct and attributes.

Three Summary Checklists of Group Interview Issues follow. The first compares women's concerns among the eight MODVOPPP health professions included in this study; the second compares men's. The third compares men's and women's responses in this profession only.

SUMMARY CHECKLIST OF FEMALE GROUP INTERVIEW ISSUES
COMPARATIVE MODVOPPP PROFESSIONS

	M	O	D	V	O	P	P	P
STRUCTURAL FEATURES								
Lack of Role Models	•	•				•		•
Lack of Support Group of Women		•				•		•
Tracked into Limited Specialties/Options	•	•	•	•		•	•	
Balancing Work/Family	•	•	•	•	•	•	•	
Women's Disadvantage in Background or Size		•	•	•				
Social Problems	•							
ABSENCE OR INADEQUACY OF FACILITIES	•	•	•	•		•		
CHARACTERISTICS OF THE PROFESSION AND ITS WORK								
Life and Death Responsibility								
Relative Status of the Profession					•			•
ABSENCE OF OR DIFFICULTY IN GAINING ACCESS TO RESOURCES								
Lack of Encouragement and/or Information	•	•	•	•	•		•	•
Access to the Informal Network	•	•	•		•	•	•	•
Absence of Required Personal Attributes	•	•	•	•	•	•	•	•
Absence or Concern about Meeting Formal Requirements			•			•	•	
Access to Financing	•	•	•	•	•	•	•	
NEGATIVE ATTITUDES/BEHAVIORS OF OTHERS								
Incidents of Sexism	•	•	•	•	•	•	•	•
Resentment by Male Peers	•	•	•	•	•	•	•	
Client Prejudices	•	•	•	•	•	•	•	
Staff/Employee Prejudices	•		•			•	•	•
IMPACT ON SELF OF TRAINING								
Double Binds	•	•	•	•		•	•	•
Women Feel Must Work Harder	•	•	•	•	•	•	•	•
Problems with Maintaining Relationships	•	•	•	•		•		
Competition and Academic Pressures								
Feeling You Must Turn off Emotions	•	•	•					•
Concern That the Training Process Changes You	•							

SUMMARY CHECKLIST OF MALE GROUP INTERVIEW ISSUES
COMPARATIVE MODVOPPP PROFESSIONS

	M	O	D	V	O	P	P	P
STRUCTURAL FEATURES								
Lack of Role Models								
Lack of Support Group of Women								
Tracked into Limited Specialties/Options								
Balancing Work/Family								
Women's Disadvantage in Background or Size								
Social Problems								
ABSENCE OR INADEQUACY OF FACILITIES								
CHARACTERISTICS OF THE PROFESSION AND ITS WORK								
Life and Death Responsibility	•	•						
Relative Status of the Profession		•	•		•	•	•	•
ABSENCE OF OR DIFFICULTY IN GAINING ACCESS TO RESOURCES								
Lack of Encouragement and/or Information								•
Access to the Informal Network								
Absence of Required Personal Attributes								
Absence or Concern about Meeting Formal Requirements		•	•		•	•	•	•
Access to Financing	•	•	•	•		•	•	
NEGATIVE ATTITUDES/BEHAVIORS OF OTHERS								
Incidents of Sexism								
Resentment by Male Peers								
Client Prejudices								
Staff/Employee Prejudices								
IMPACT ON SELF OF TRAINING								
Double Binds								
Women Feel Must Work Harder								
Problems with Maintaining Relationships	•	•		•		•		
Competition and Academic Pressures	•	•	•	•		•	•	•
Feeling You Must Turn off Emotions								
Concern That the Training Process Changes You	•	•						

SUMMARY CHECKLIST OF GROUP INTERVIEW ISSUES

PODIATRY

	WOMEN	MEN
STRUCTURAL FEATURES		
Lack of Role Models	•	
Lack of Support Group of Women	•	
Tracked into Limited Specialties/Options	•	
Balancing Work/Family	•	
Women's Disadvantage in Background or Size		
Social Problems		
ABSENCE OR INADEQUACY OF FACILITIES	•	
CHARACTERISTICS OF THE PROFESSION AND ITS WORK		
Life and Death Responsibility		
Relative Status of the Profession		•
ABSENCE OF OR DIFFICULTY IN GAINING ACCESS TO RESOURCES		
Lack of Encouragement and/or Information		
Access to the Informal Network	•	
Absence of Required Personal Attributes	•	
Absence or Concern about Meeting Formal Requirements	•	•
Access to Financing	•	•
NEGATIVE ATTITUDES/BEHAVIORS OF OTHERS		
Incidents of Sexism	•	
Resentment by Male Peers	•	
Client Prejudices	•	
Staff/Employee Prejudices	•	
IMPACT ON SELF OF TRAINING		
Double Binds	•	
Women Feel Must Work Harder	•	
Problems with Maintaining Relationships	•	•
Competition and Academic Pressures		•
Feeling you must Turn off Emotions		
Concern that the Training Process Changes You		

APPENDIX D

SUMMARIES OF CHARACTERISTICS OF SCHOOLS AND INTERVIEW RESPONDENTS IN EIGHT MODVOPPP PROFESSIONS

SCHOOL VISIT SITE SELECTION BY CHARACTERISTICS

	# of Field Sites	Urban	Rural	North Central (1)	South	Northeast	West	Public	Private	Free-Standing	Univ. Affiliate	Physically Indep.	Medical Center	Part of Campus	High Status (2)	Low Status (2)	High % Women Enrolled (3)	Low % Women Enrolled (3)
Medicine	9	8	1	1	3	2	3	5	4	1	8	1	2	6	6	3	7	2
Osteo. Med. (4)	2	-	-	-	-	-	-	-	-	-	-	-	-	-	N/A	N/A	1	1
Dentistry	5	5	Ø	Ø	2	1	2	3	2	Ø	5	1	2	2	2	3	4	1
Vet. Med.	2	1	1	1	Ø	Ø	1	2	Ø	Ø	2	Ø	Ø	2	N/A	N/A	1	1
Optometry	2	2	Ø	Ø	Ø	1	1	1	1	1	1	1	Ø	1	1	1	1	1
Podiatry (4)	2	-	-	-	-	-	-	-	-	-	-	-	-	-	N/A	N/A	2	Ø
Pharmacy	3	3	Ø	Ø	Ø	1	2	1	2	1	2	1	1	1	1	2	2	1
Pub. Hlth.	2	2	Ø	Ø	1	Ø	1	1	1	Ø	2	1	Ø	1	2	Ø	2	Ø
TOTAL	27	21	2	2	6	5	10	13	10	3	20	5	5	13	N/A	N/A	20	7

(1) The four regions are comprised of the following states:

North Central: Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Ohio, Idaho, Wisconsin, Kansas, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming.

South: District of Columbia, Maryland, West Virginia, Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia.

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Delaware, New Jersey, New York, Pennsylvania.

West: Arizona, New Mexico, Oklahoma, Texas, Colorado, Alaska, California, Hawaii, Nevada, Oregon, Washington

(2) Where known or applicable, status is defined as the degree of respect accorded a given institution by members of the same profession.

(3) Higher or lower than the national proportion of women enrolled by profession.

(4) This information has been intentionally omitted since the combination of characteristics might identify which schools were visited. Thus totals for site characteristics do not add to 27.

SUMMARY OF INDIVIDUAL INTERVIEWS

		Administrator Interviews															Faculty Interviews								
	# of Schools	Deans, Presidents, Chancellors			Asst. or Assoc. Deans			Affirmative Action (1)			Other Admin. (2)			Total Admin.			Pre-Clinical Faculty			Clinical Faculty			Total Faculty		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
Medicine	9	10	--	10	11	5	16	--	5(1)	5(1)	11	15	26	32	25	57	8	13	21	19	21	40	27	34	61
Osteo. Med.	2	3	--	3	4	--	4	--	--	--	4	1	5	11	1	12	5	--	5	4	6	10	9	6	15
Dentistry	5	5	--	5	13	--	13	--	--	--	1	4	5	19	4	23	5	3	8	16	5	21	21	8	29
Vet. Med.	2	1	--	1	4	--	4	--	1	1	3	2	5	8	3	11	2	2	4	9	5	14	11	7	18
Optometry	2	3	--	3	2	--	2	--	--	--	2	2	4	7	2	9	4	1	5	3	1	4	7	2	9
Podiatry	2	2	--	2	3	1	4	1	--	1	1	2	3	7	3	10	3	10	13	5	1	6	8	11	19
Pharmacy	3	3	--	3	6	--	6	--	--	--	5	6	11	14	6	20	4	3	7	5	4	9	10	7	17
Pub. Hlth. (5)	2	1	--	1	2	1	3	--	--	--	--	1	1	3	2	5	N/A	N/A	N/A	5	5	10	5	5	10
TOTALS	27	28	--	28	45	7	52	1	6	7	27	33	60	101	46	147	31	32	63	67	48	114	98	80	178

(1) Of the 5 Affirmative Action, 4 were university-wide and therefore covered, in three instances, dentistry, and in one instance, pharmacy, as well as medicine.

(2) Includes Registrars, Business Managers, Administrative Assistants, Directors of Special Programs, Centers, Institutes or Grants, Financial Aid Officers.

SUMMARY OF INDIVIDUAL INTERVIEWS (Continued)

Individual Student Interviews																		Intern & Resident Interviews									Total Respondents		
1st Year			2nd Year			3rd Year			4th Year			Unknown Or "Other" Students			Total Individual Students (3)			Site Admin.			Interns & Residents			Total Admin., Interns & Residents					
M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
6	21	27	4	13	17	2	9	11	1	5	6	2	13	15	15	61	76	3	1	4	9	11	20	12	12	24	86	132	218
3	3	6	1	2	3	2	4	6	--	1	1	--	--	--	6	10	16	←				N/A				→	26	17	43
1	7	8	5	9	14	1	--	1	2	7	9	4	1	5	13	24	37	1	--	1	--	2	2	1	1	2	54	37	91
5	4	9	2	5	7	--	4	4	--	2	2	--	1	1		16	23	1	--	1	2	3	5	3	3	6	29	29	58
--	4	4	1	5	6	3	2	5	1	5	6	--	--	--	5	16	21	←				N/A				→	19	20	39
--	1	1	--	2	2	1	2	3	4	2	6	--	--	--	5	7	12	1	--	1	3	--	3	4	--	4	24	21	45
--	1	1	--	5	5	1	7	8	1	2	3	6	7(4)	13(4)	8	22	30	←				N/A				→	32	35	66
6	7	13	--	--	--	--	--	--	--	--	--	--	--	--	6	7	13	1	--	1	2	4	6	3	4	7	17	18	35
21	48	69	13	41	54	10	28	38	9	24	33	12	22	34	65	163	228	7	--	7	16	20	36	23	20	43	287	309	595

(3) Male students were not a key respondent group in the study until after submission of the Interim Report at which time the study's focus was expanded to include them in greater numbers. The imbalance between male and female student interviews remains because URSA visited half of the schools in the study (14 of 27) prior to the Interim Report.

(4) Includes 1 fifth-year and 1 sixth-year student.

(5) Hospital Administration and Epidemiology faculty and students combined. Due to varying lengths of training programs, all Public Health students arbitrarily counted as first-year students.

MODVOPPP GROUP INTERVIEW SUMMARY

	Male		Female		Mixed		Total	
	# of Groups	Estimated Average N=7	# of Groups	Estimated Average N=7	# of Groups	Estimated Average N=8	# of Groups	Estimated Total
Medicine	4	28	13	91	--	--	17	119
Osteo. Med.	3	21	3	21	1	8	7	50
Dentistry	1	7	8	56	1	8	10	71
Vet. Med.	--	--	5	35	3	24	8	59
Optometry	2	14	3	21	1	8	6	43
Podiatry	1	7	2	14	--	--	3	21
Pharmacy	2	14	6	42	1	8	9	64
Pub. Hlth.	1	7	1	7	--	--	2	14
TOTAL	14	98	41	287	7	56	62	441